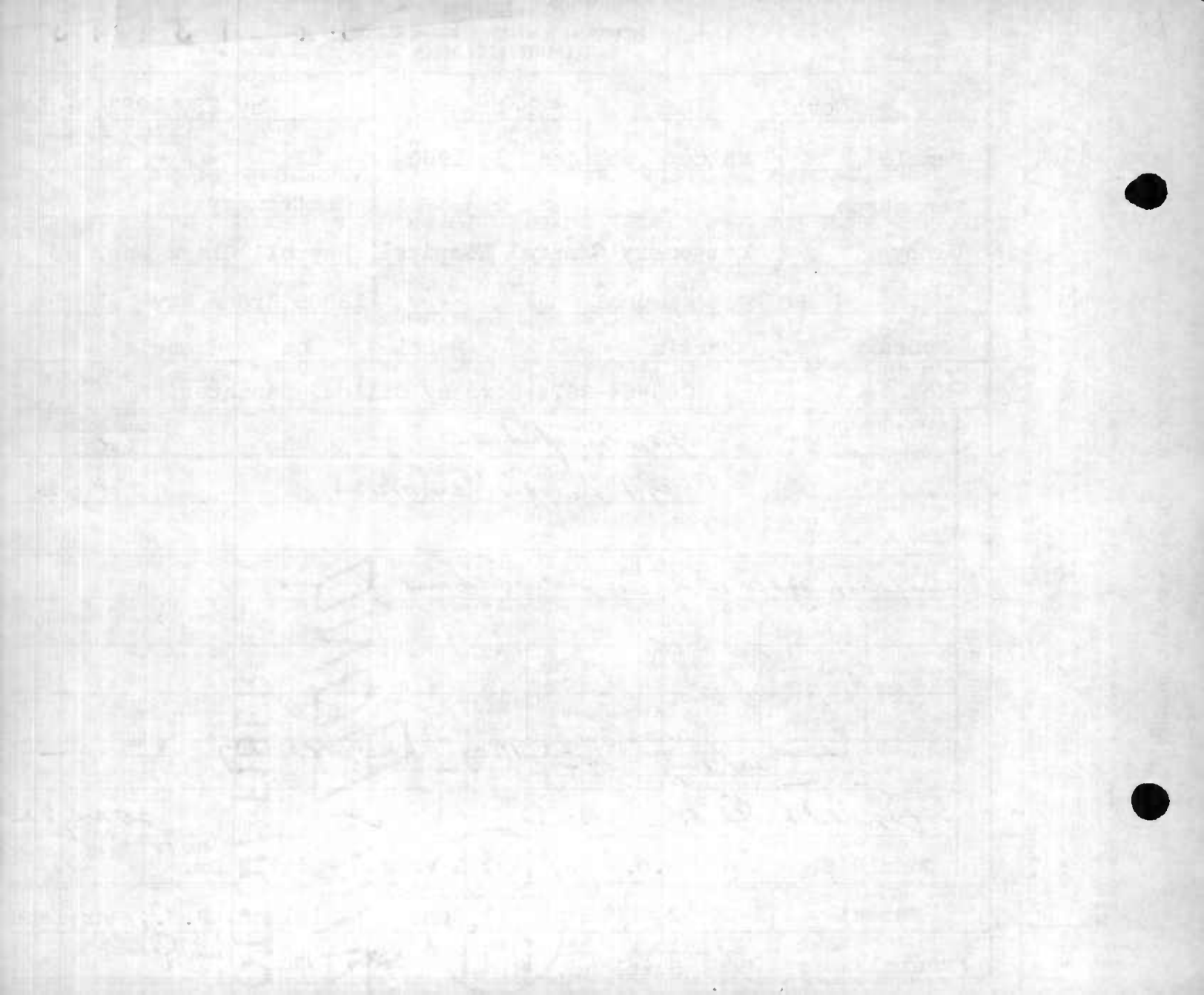


DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nova Lee Abbott			2a. DATE OF DEATH MONTH DAY YEAR May 25, 1982		2b. HOUR 9:45AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 3 1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Payroll Clerk	12b. KIND OF BUSINESS OR INDUSTRY Engraving Bur. of	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PG 13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1300 Arden Way #7	
14. FATHER'S NAME FIRST MIDDLE LAST Ephraim B. Martin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Bu Gunnels		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 263-64-3674	17. INFORMANT ADDRESS Same as Above Dorothy Dillon, Daughter,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 5715 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Post-neurotic cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d. 3-4 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardiomyopathy and congestive heart failure.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>23 May</u> , 19 <u>82</u> , to <u>25 May</u> , 19 <u>82</u> , that (I) lost saw the deceased alive on <u>24 May</u> , 19 <u>82</u> , and that in my own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.					
22b. SIGNATURE <u>Donald E. Dillon</u>		DEGREE M.D.		22c. DATE SIGNED 25 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.		22e. ADDRESS Olney, Md. 18111 Prince Phillip Dr. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-28-82	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland
24. FUNERAL DIRECTOR NAME Robt E Wilhelm Funeral Home Rd., Suitland, Md.		ADDRESS 4308 Suitland		25a. DATE REC'D. BY REGISTRAR JUN 3 1982	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

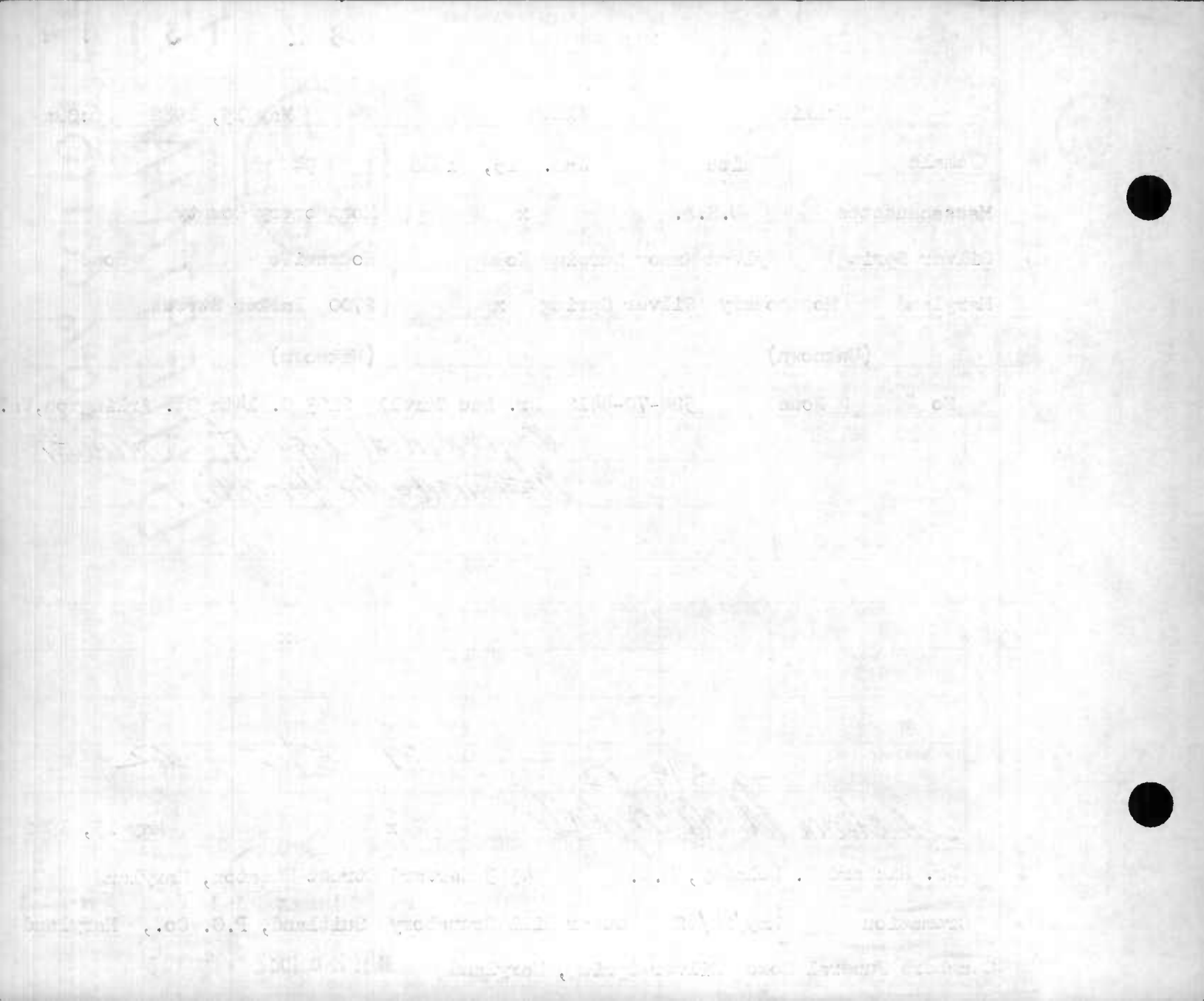


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the removal of the body from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 4 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Nellie Allen				2a. DATE OF DEATH MONTH DAY YEAR May 15, 1982		2b. HOUR 6:00a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Dr. Lee Gurell 2123 S. 14th St. Arlington, Va.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/9/82 to 5/15/82, that (I) (we) lost saw the deceased alive on 5/9/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard P. Delaney, M.D.				22c. DATE SIGNED May 15, 1982		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard P. Delaney, M.D.				22f. ADDRESS 4323 Harvard Street Wheaton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 24/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE MAY 26 1982			



BP
DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 2 1 3 1 4 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HEZEKIAH ALSTON					2a. DATE OF DEATH MONTH DAY YEAR 5 24 82 2b. HOUR 6 30 PM				
3. SEX MALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 16 23		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL-PRE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE D.C.		13b. COUNTY WASHINGTON		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 22 SEATON PL. NW			
14. FATHER'S NAME FIRST MIDDLE LAST AARON ALTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ICINA BOLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 248-24-9680		17. INFORMANT ADDRESS JOSEPH ALSTON (BROTHER) same as 13e			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Scleroderma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11 Feb 1982 to 24 May 1982 , that (I) (we) last saw the deceased alive on 24 May 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Merton L. White MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 24 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Merton L. WHITE MD.				22e. ADDRESS 9911 Georgia Ave Silver Spring Md 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-29-82		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEN. CEM.		23d. LOCATION SUITLAND MARYLAND STATE			
24. FUNERAL DIRECTOR NAME FRAZIER'S				ADDRESS 389 R.I. AVE. N.W.					

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13146	
1. DECEASED NAME (TYPE OR PRINT) JONATHAN LEIGH ALTMAN						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 18 1982		2b. HOUR 3:30 PM			
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 7 26 52	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 29	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 18 1982		2d. HOUR 3:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK CITY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Systems Analyst		12b. KIND OF BUSINESS OR INDUSTRY Comsat			
13a. STATE MD				13b. CITY OR TOWN COLUMBIA		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Frank Altman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys P. Phillips							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 105-40-2471		17. INFORMANT 9433 Indian Camp Road Shing-Mei Jocelyn Altman; Columbia, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMA 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AUTOMOBILE DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 5/18/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? CRUSHED CHEST - TUBE				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11:05 P.M. 5 18 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CAR CROSSED MIDLINE AND HIT HIM							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ROUTE 118 GERMAN TOWN MONT. MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Francis P. Mahle</i>		TITLE (SPECIFY) DEPT		M.D.		MEDICAL EXAMINER		DATE SIGNED 5/18/82			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS P MAHLE		ADDRESS 8200 WISCONSIN AVE BETHESDA MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-20-82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Reisterstown, Maryland					
24. FUNERAL DIRECTOR 1170 Rockville Pike; Rockville, Md.						25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

Journal - 1891

At Camp 7 20/2/91

Received from Mr. [illegible]

the sum of [illegible]

for [illegible]

Received from Mr. [illegible]

the sum of [illegible]

for [illegible]

Received from Mr. [illegible]

the sum of [illegible]

for [illegible]

Received from Mr. [illegible]

the sum of [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 1 4 7
CERTIFICATE OF DEATH

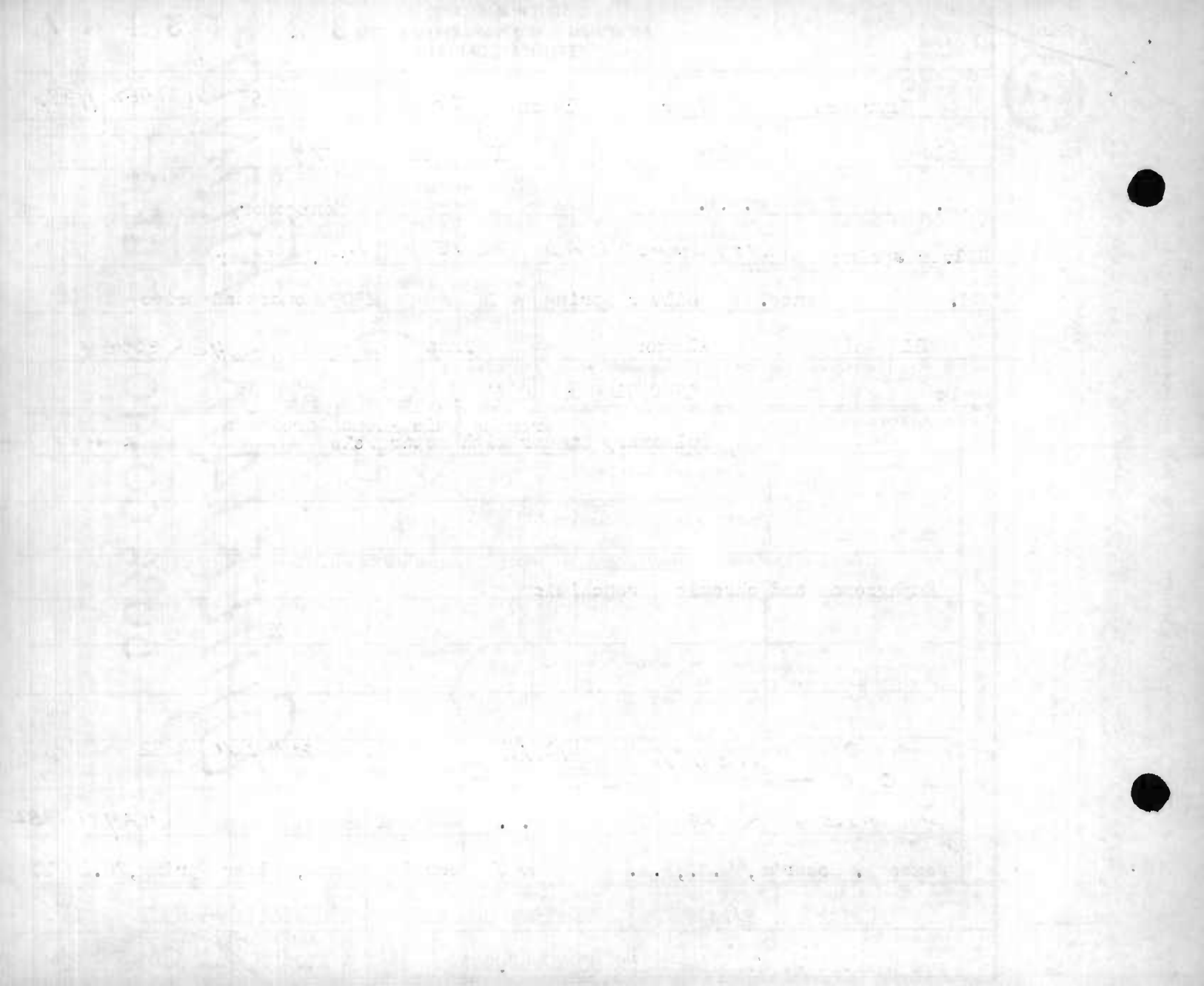
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence Edgar Altman SR.				2a. DATE OF DEATH MONTH DAY YEAR 5 11 1982			
1. SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 5 XXX 02		6 AGE (IN YEARS LAST BIRTHDAY) 79	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2309 HOMESTEAD DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BLDG. Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.		13b COUNTY Montg.		13c CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST XXXX ELY Altman				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna McKELVEY			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 176057149 A		17. INFORMANT ADDRESS CORA M. ALTMAN SAME AS 13 WIFE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Pulmonary Cancer with metastasis (6 mos)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>(b) _____</div> <div>(c) _____</div> </div>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema and chronic Bronchitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/15/75 , 19 82 , to MAY 11 , 19 82 , that (I) (we) lost saw the deceased alive on MAY 11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James A. Roberts				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 11, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Roberts, M.D., P.A.				22e. ADDRESS 8907 Georgia Avenue, Silver Spring, Md. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	3	1	4	8
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Georgette Marie AMES										2a. DATE OF DEATH MONTH 5 DAY 28 YEAR 82 2b. HOUR 5:45 AM						
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH Jan. DAY 7 YEAR 1938			6. AGE (IN YEARS (LAST BIRTHDAY)) 44 YRS			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 74 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11222 Empire Lane							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11222 Empire Lane							
14. FATHER'S NAME FIRST Anthony MIDDLE LAST Canova					15. MOTHER'S MAIDEN NAME FIRST Georgetta MIDDLE LAST Preto											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-32-1305			17. INFORMANT ADDRESS F. Peasson Ames, Same As #13e										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Carcinoma of The Lung IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF metastatic To Brain (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year.																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 										
22a. I certify that (I) (the doctor) attended the deceased from 4-15 , 19 82 , to 5-28 , 19 82 , that (I) (myself) saw the deceased alive on 5-26 , 19 82 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.																
22b. SIGNATURE John F. Tauber					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5-28-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Tauber					22e. ADDRESS 8218 Wisconsin Ave, Bethesda											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-31-82		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial			23d. LOCATION CITY OR TOWN Parkville, Balto., COUNTY Maryland STATE 								
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204					25a. DATE REC'D. BY REGISTRAR JUN 2 1982					25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]						

10-22-52

4-22

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

10-22-52

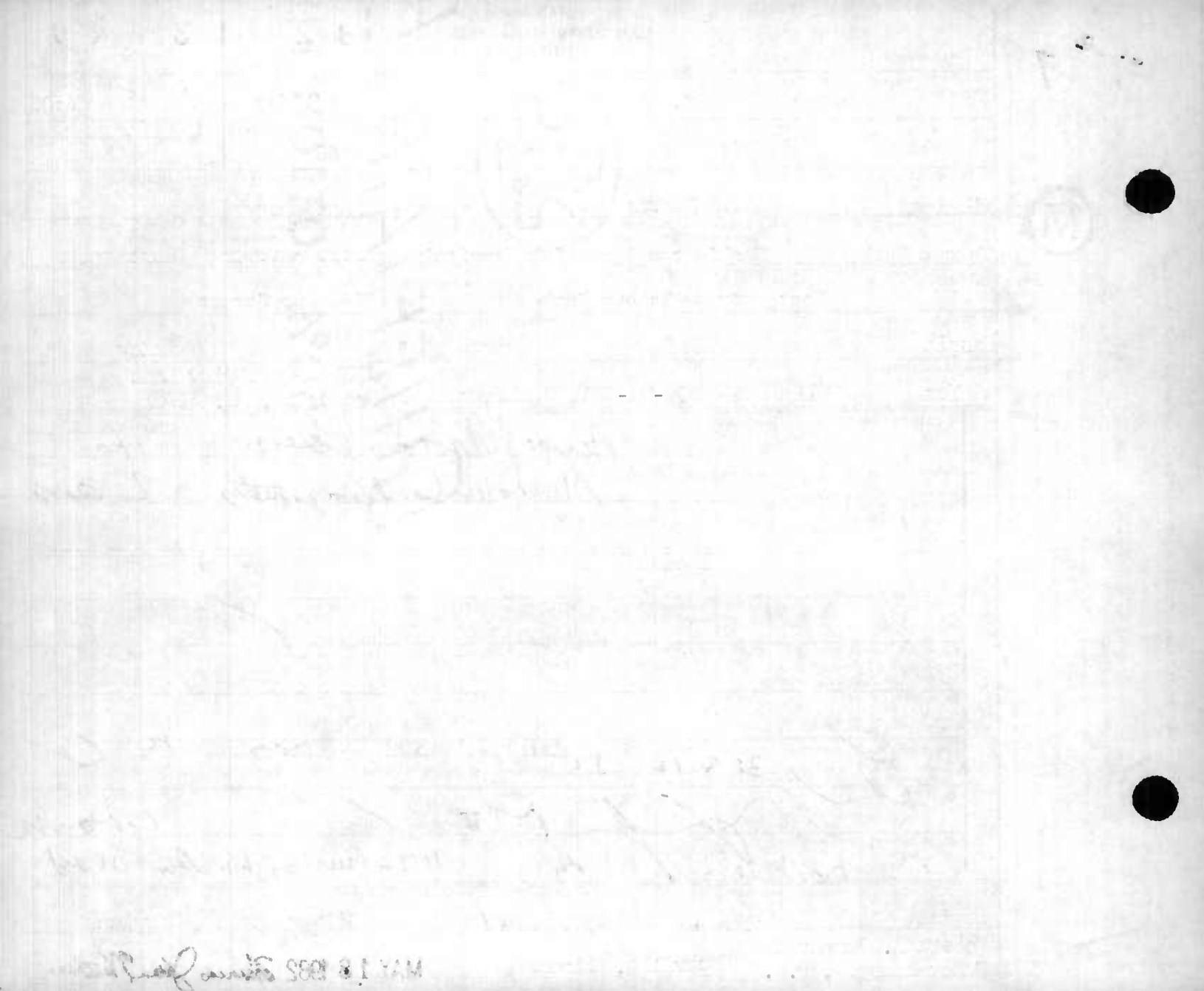
10-22-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	3	1	4	9
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Joseph S. Amin										2a. DATE OF DEATH MONTH DAY YEAR 5/14/82				2b. HOUR 6:05 AM		
3 SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR 2-3-14			6. AGE (IN YEARS LAST BIRTHDAY) 68			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur			12b. KIND OF BUSINESS OR INDUSTRY Restaurant							
13a. STATE Md			13b. COUNTY Montgomery			13c. CITY OR TOWN Takoma Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 910 Anne Street				
14. FATHER'S NAME FIRST MIDDLE LAST Hassin Amin						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mickey										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. WW11		17. INFORMANT ADDRESS 5771 Sunset View Lane Richard Amin Frederick, Md. 21701								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4255 Acute Pulmonary Edema (b) Alcoholic Cardiomyopathy (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 years																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 19 81, to May 19 82, that (I) (we) lost saw the deceased alive on 30 April 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Michael K. Smith, M.D.						DEGREE ENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 14 June 82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael K. Smith, M.D.						22e. ADDRESS 11120 New Hampshire Ave S.S. Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE May 18, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland				
24. FUNERAL DIRECTOR Robert A. Pumphret Funeral Homes, P.A., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 18 1982				25b. REGISTRAR'S SIGNATURE James J. Nathan						



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 5 0

1. FOR
STATE
REGISTRAR

REG. NO.

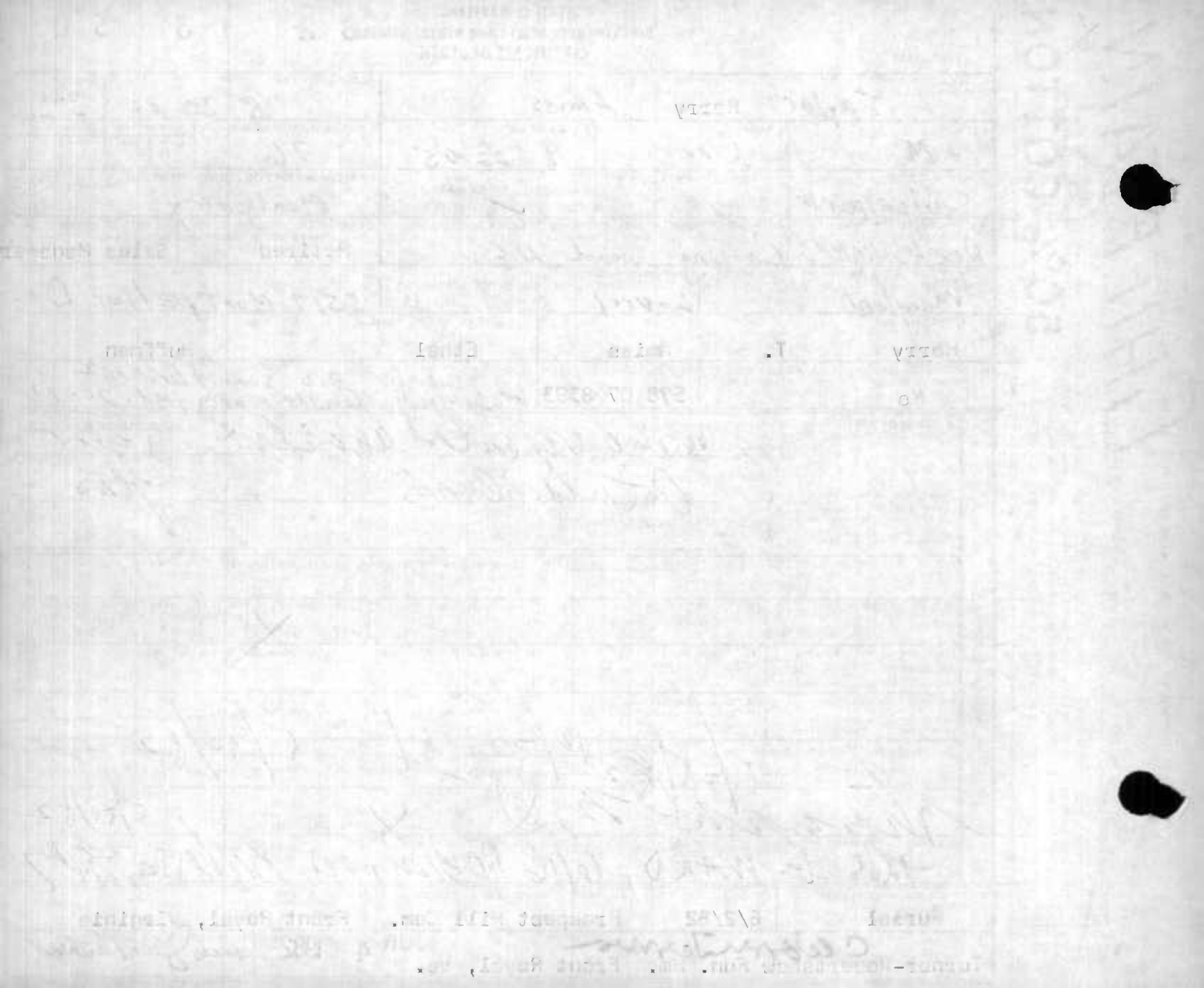
1. DECEASED NAME (TYPE OR PRINT) Taylor Harry Amiss			2a. DATE OF DEATH MONTH DAY YEAR 5 30 82			2b. HOUR 3:40 P.M.				
3. SEX M		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 9 22 05		6. AGE (IN YEARS LAST BIRTHDAY) 76 YES		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Culpepper Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood N.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Sales Manager		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8517 Montpelier Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST Harry T. Amiss		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Huffman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						
16b. SOCIAL SECURITY NO. 578 07 8393		17. INFORMANT W. Smith Jr., 214 Summit Dr. #102, Gaithersburg, Md. 20877								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) glau APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 glau										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/30 8/19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/30/82 to 5/30/82 that (I) (we) last saw the deceased alive on 5/30/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two) (If only one) did not view the body after death.										
22b. SIGNATURE Thos G. Ward			22c. ADDRESS 6116 Robinwood, Bethesda, Md 20814			22d. DATE SIGNED 5/30/82		22e. SIGNATURE Thos G. Ward		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/2/82			23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Front Royal Virginia	
24. FUNERAL DIRECTOR NAME C. W. Turner			24b. ADDRESS Turner-Robertshaw Fun. Hm. Front Royal, Va.			25. DATE, REG'D. BY, AND FRACTIONAL REGISTRAR'S SIGNATURE JUN 4 1982 Frances Jan. Nathan				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lois N. Amos		2a. DATE OF DEATH MONTH DAY YEAR May 20 1982		2b. HOUR 5:30AM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 15 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Levi M. Noffsinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 068-22-8408		17. INFORMANT ADDRESS P.O. Box 118 Centreville, Md. 21617	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Severe pneumonia due to 4824 DUE TO, OR AS A CONSEQUENCE OF Lophylococcus and gram neg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 days DUE TO, OR AS A CONSEQUENCE OF ② Cerebral arteriosclerosis (c) c post CVA - 9/6/81 aphasia 4 1/2 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(was hospitalized)</u> attended the deceased from <u>December 19 77</u> to <u>20 May 19 82</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>20 May 19 82</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.			
22b. SIGNATURE Gustavo S. Belaval		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 20 May 82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUSTAVO S. BELAVAL		22e. ADDRESS Leisure World Medical Center Silver Spring, Md 20906	

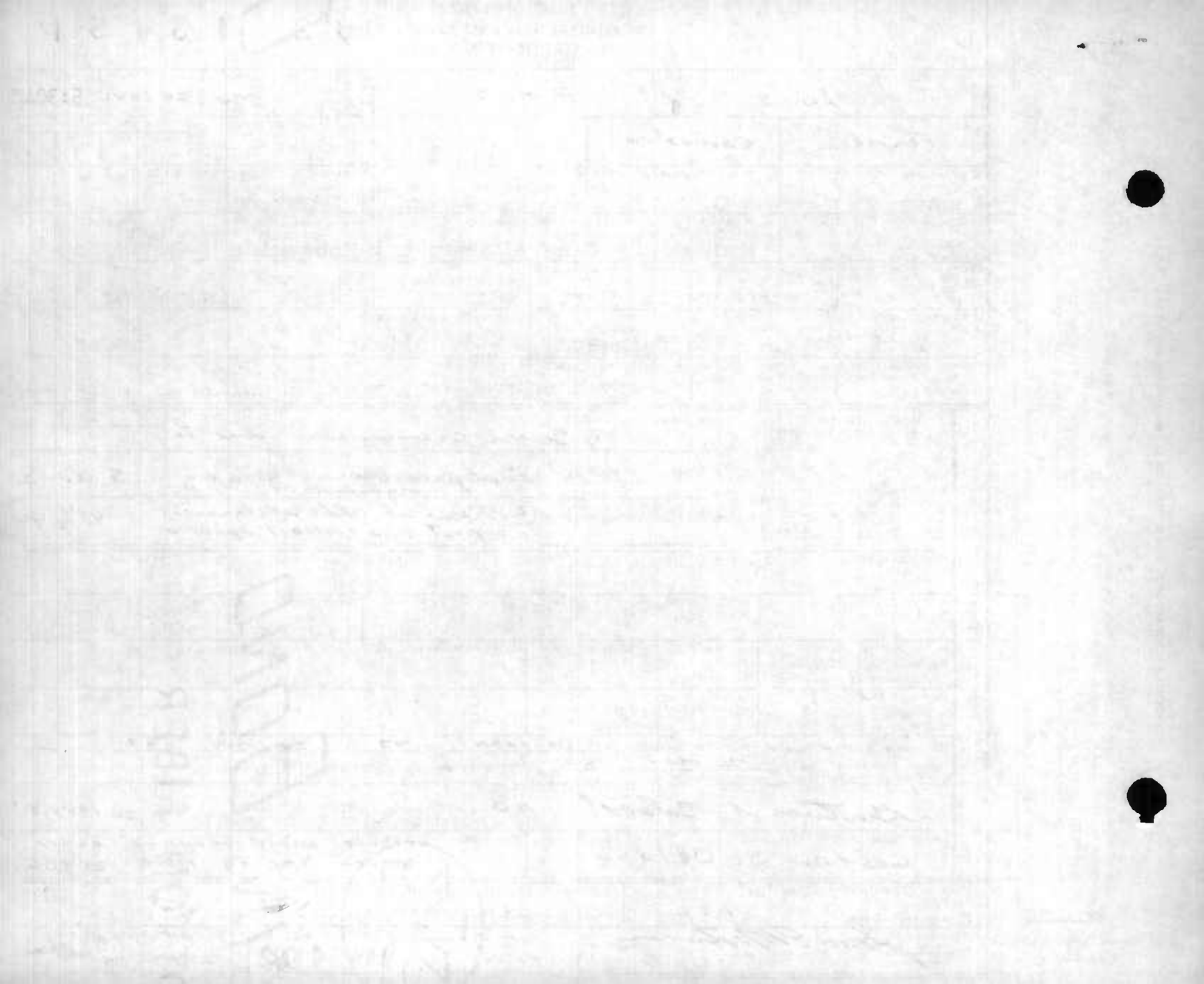
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 5/21/82	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. ADDRESS P.O. Box 7428 Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR MAY 24 1982 25b. REGISTRAR'S SIGNATURE James Santhorn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John S. Anastasi				2a. DATE OF DEATH MONTH DAY YEAR May 5, 1982		2b. HOUR 7:20p M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 12, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital Sil Spr Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICK MASON		12b. KIND OF BUSINESS OR INDUSTRY LITTERIO CONST.	
13a. STATE MD 13b. CITY OR TOWN WASHINGTON, D.C. 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 7429 9TH STREET, N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST PLACIT ANASTASI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA REGGI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 577-26-9935		17. INFORMANT MARY T. ANASTASI		ADDRESS SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4940 DUE TO, OR AS A CONSEQUENCE OF (b) Bronchiectasis DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that D (this hospital) attended the deceased from 1/81 19 81 to 5/5 19 82 that 0 (we) last saw the deceased alive on 5/4/ 19 82 , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (0) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jay Warner MD DEGREE				22c. DATE SIGNED 5/6/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Warner MD	
22e. ADDRESS 4701 Randolph Rd, Rockville, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/8/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lawrence Union Appleman										2a. DATE KNOWN OF DEATH May 13 1982	
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 90 92	6. AGE (IN YEARS) (LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD May 13 1982		2b. HOUR 8 M 20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4404 Dresden St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired U.S. Gov't.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY Montg		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 4404 Dresden St.			
14. FATHER'S NAME FIRST MIDDLE LAST John P. Appleman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Zentmeyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES) ---		16b. SOCIAL SECURITY NO. 215-34-3024		17. INFORMANT ADDRESS Nancy A. Eynon 7505 Brookville Rd. Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Dep. M.D. MEDICAL EXAMINER				DATE SIGNED May 13, 1982			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS 1919 Seminary Rd. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE Thomas J. ...			

... von ... U ...

•

2199

• 67-1054 - 1967 Buick Wildcat

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise		FIRST Louise MIDDLE Aschenbrenner LAST Aschenbrenner		2a. DATE OF DEATH MONTH May DAY 15 YEAR 1982		2b. HOUR 5:20 A M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH 11 DAY 12 YEAR 94		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS DAYS HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Retir. & Nursing Cen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5101 Ridgefield Road	
-----------------------------------------------------------------------------------------	--	-----------------------	--	-------------------------------	--	-----------------------------------	--	-----------------------------------------------------------------------------------	--	-------------------------------------------------	--

14. FATHER'S NAME FIRST George MIDDLE LAST Baur		15. MOTHER'S MAIDEN NAME FIRST Auguste MIDDLE LAST Wachter	
-----------------------------------------------------------------------	--	----------------------------------------------------------------------------------	--

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 455-35-6353		17 INFORMANT Bert C. Aschenbrenner		ADDRESS Annapolis, Md.	
-----------------------------------------------------------------------------	--	--------------------------------------------	--	-------------------------------------------	--	-------------------------------	--

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Right Lung DUE TO, OR AS A CONSEQUENCE OF (b) 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours	
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------	--

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease	
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	--------------------------------------------------	--	------------------------------------------------------------------------	--	-------------------------------------------------------------------------------------------------------------------------	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
----------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------	--	--------------------------------------------------------------------------------	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
----------------------------------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------	--	------------------------------------------------	--

22a. I certify that (1) this hospital attended the deceased from February 5/14/82 to 5/15/82 , that (1) last saw the deceased alive on 5/14/82 , and that in my (own) opinion death occurred on the date and hour and from the causes stated above, if possible view the body after death	
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. SIGNATURE Blaine Fitzgerald DEGREE		22b. DATE SIGNED 5/15/82	
------------------------------------------------	--	---------------------------------	--

22a. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.		22b. ADDRESS 8218 Wisc. Ave., Bethesda, Maryland. 20814	
-------------------------------------------------------------------------	--	----------------------------------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/17/1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland.	
------------------------------------------------------------	--	----------------------------	--	----------------------------------------------------------------	--	--------------------------------------------------------------------	--

24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc		25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan	
-----------------------------------------------------	--	--------------------------------------------------	--	---------------------------------------------------	--

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM ELMER AYTON										2a. DATE KNOWN OF DEATH ESTIMATED 5 18 82										2b. HOUR 8 P M	
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH NOV DAY 2 YEAR 1907		6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD 5 18 82		2d. HOUR 6 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH GAITHERSBURG				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6112 ONLY LAYTONSVILLE RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSEMAN				12b. KIND OF BUSINESS OR INDUSTRY NURSERY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6112 ONLY LAYTONSVILLE RD													
14. FATHER'S NAME FIRST JAYN MIDDLE WILLIAM LAST AYTON					15. MOTHER'S MAIDEN NAME FIRST ZADIE MIDDLE E LAST AYTON																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 574-099336					17. INFORMANT Charles E Ayton 60101 only Laytonville Rd. Gaithersburg, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9560 EXSANGUINATION Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) LACERATION OF WRIST (c) 1 hr										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). DEPRESSION																					
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 3 AM 18 MONTH 10 DAY 82 YEAR 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CUT WRISTS ELBOWS													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET 6112 ONLY LAYTONSVILLE RD CITY OR TOWN GAITHERSBURG COUNTY MONTGOMERY STATE MD													
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Francis C Mayle				TITLE (SPECIFY) Sept				MEDICAL EXAMINER Francis C Mayle				DATE SIGNED 5/18/82									
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle				ADDRESS 6112 ONLY LAYTONSVILLE RD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Laytonville Cemetery				23d. LOCATION CITY OR TOWN Laytonville COUNTY Montg STATE MD											
24. FUNERAL DIRECTOR NAME Francis H. Barber ADDRESS Laytonville, Md. 20879										25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE Francis H. Barber									

1970

MEMORANDUM FOR THE RECORD

1970

The following information was obtained from the files of the Department of the Interior, Bureau of Land Management, regarding the proposed acquisition of the land described in the attached map.

The land is located in the State of California, County of San Diego, and is owned by the State of California. The land is situated in the vicinity of the San Diego River and is adjacent to the San Diego River.

The land is situated in the vicinity of the San Diego River and is adjacent to the San Diego River. The land is situated in the vicinity of the San Diego River and is adjacent to the San Diego River.

The land is situated in the vicinity of the San Diego River and is adjacent to the San Diego River. The land is situated in the vicinity of the San Diego River and is adjacent to the San Diego River.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 5 6

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT A BAKEMAN			2a. DATE OF DEATH MONTH DAY YEAR 5-22-82		2b. HOUR 12:40a		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-30-10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY USA 13c. CITY OR TOWN Takoma Park 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 214 Domer Ave							
14. FATHER'S NAME FIRST MIDDLE LAST Robert A. Bakeman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST June Dunn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Jessie Bakeman, Wife, Same as Above			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO, OR AS A CONSEQUENCE OF (b) Old myocardial infarctions DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary edema Carcinoma of ascending colon							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR —		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (I) (the hospital) attended the deceased from May 21, 1982 to May 22, 1982 , that (I) (we) last saw the deceased alive on May 22, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles J. Bier, M.D.				DEGREE M.D.		22c. DATE SIGNED 5-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. BIER, M.D.				22e. ADDRESS 1145-19th St. N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-24-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY TOWN COUNTY STATE Suitland, P.G., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robt E Wilhelm 4308 Suitland Rd., Suitland, Md.				25a. DATE REC'D. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE Rose Jan...	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 5 7			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST LILLIAN R. BAKER				MONTH DAY YEAR 5-20-82			
3. SEX FEMALE				2b. HOUR 9:35 M			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-10-11		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. UNDER 1 YEAR MONTHS DAYS 10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Montgomery				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13c. CITY OR TOWN Rockville				13d. STREET ADDRESS 2 Burgundy Court			
14. FATHER'S NAME FIRST MIDDLE LAST James C. Quigley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Hoffmaster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-24-3126			
17. INFORMANT ADDRESS Cecil Q. Baker R D 8, York, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cholangiocarcinoma							
19a. DATE OF OPERATION 4/28				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholangiocarcinoma			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11500 Old Georgetown Rd. Rockville, Md							
22a. I certify that (I) (the hospital) attended the deceased from 4/28 , 19 82 , to 5/20 , 19 82 , that (I) (we) last saw the deceased alive on 5/20/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Stephen J. Newman				22c. DATE SIGNED 5/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman				22e. ADDRESS 11500 Old Georgetown Rd. Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 24, 1982			
23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE RECEIVED BY REGISTRAR MAY 25 1982			
25b. REGISTRAR'S SIGNATURE Anna J. Smith							

RECEIVED

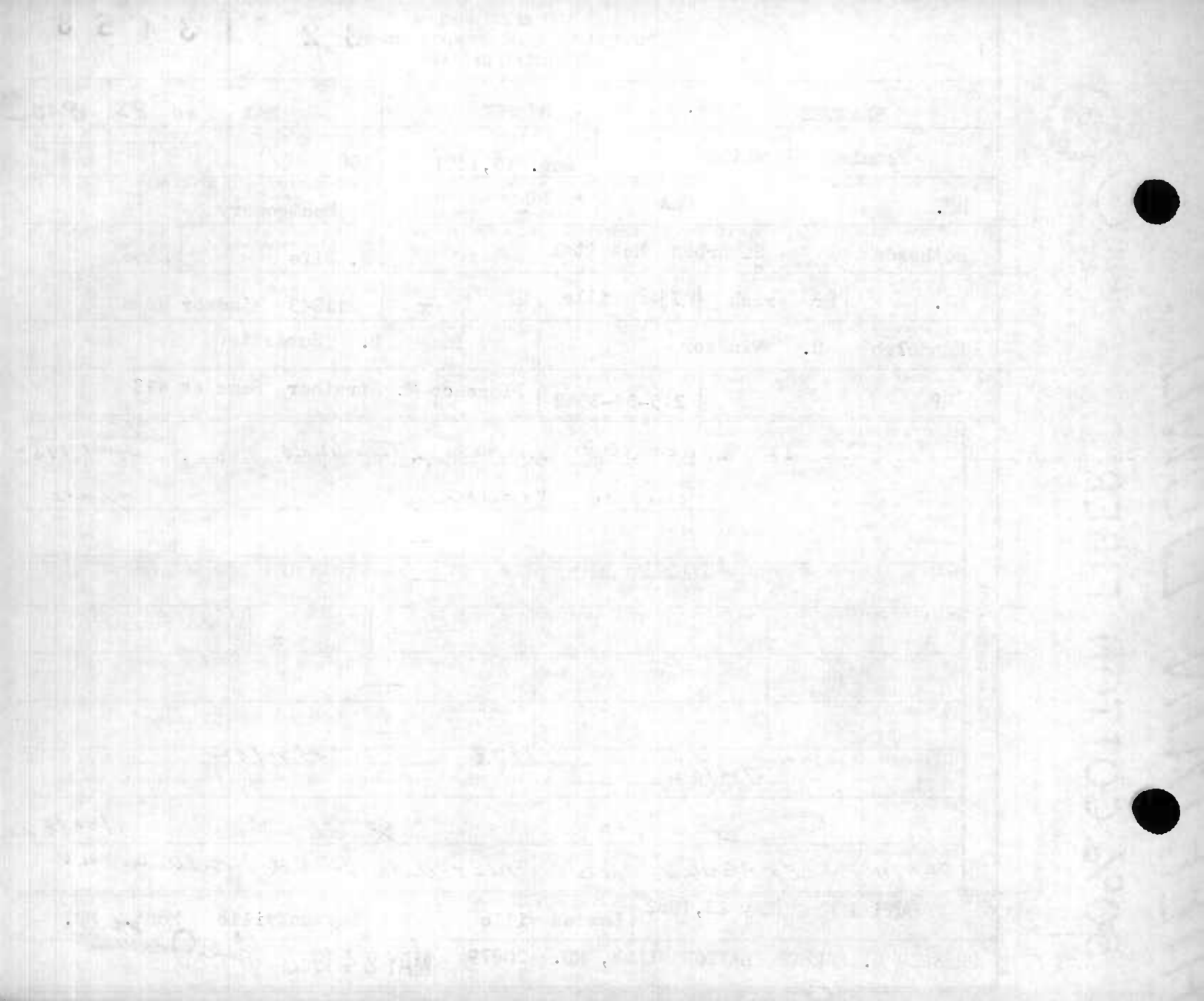
W. H. B. 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 2 1 3 1 5 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
BLANCHE W. BARBER					MAY 20 82 8:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		white		Aug. 18, 1891		90 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				H. Wife		Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Frederick		Hampsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11243 Windsor Road	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Randolph H. Windsor					Ida P. Burdette				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no					215-38-3062		Florence W. Strother Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>aspirated pneumonia, Terminal</i>									April 1982
4380 DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerebral thromboses</i>									years
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> 19 <i>5/30/82</i> 19 <i>5/30/82</i> that (I) (we) lost saw the deceased alive on <i>5/30/82</i> 19 <i>5/30/82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>[Signature]</i> MD								<i>5/30/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
OSOTH LEKAGUL MD					7425 Arlington Rd Bethesda MD				
23a. BURIAL, CREMATION REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		May 22, 1982		Laytonsville		Laytonsville Mont. Md.			
24. FUNERAL DIRECTOR						25. DATE REC'D BY REGISTRAR			
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						MAY 24 1982 <i>[Signature]</i>			

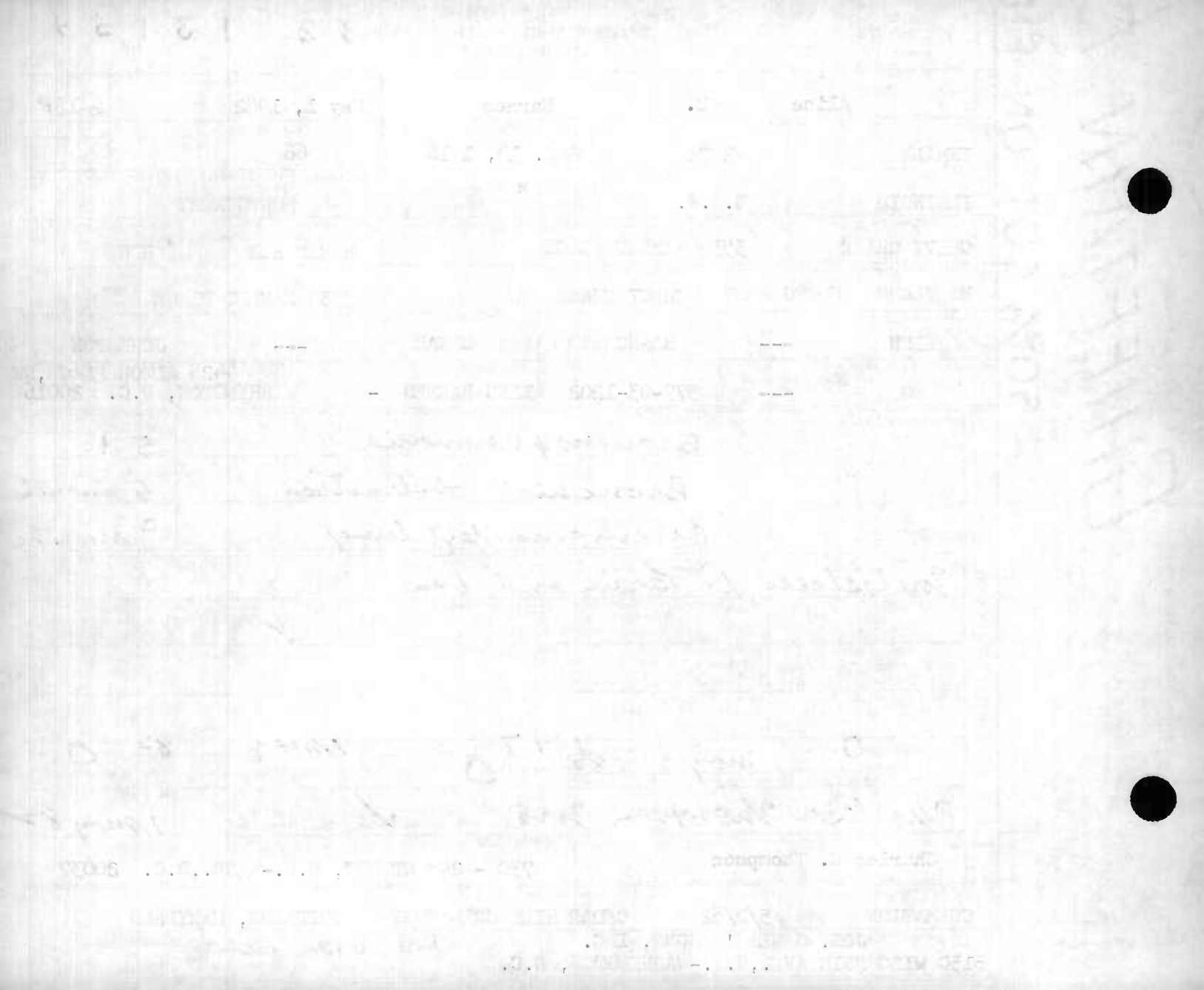


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 1 5 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice B. Barnes				2a. DATE OF DEATH MONTH DAY YEAR May 1, 1982				2b. HOUR 605P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3539 HAMLET PLACE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3539 HAMLET PLACE			
14. FATHER'S NAME FIRST MIDDLE LAST LINN --- BLANCHARD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH --- JOHNSTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) ---		16b. SOCIAL SECURITY NO. 577-03-1202		17. INFORMANT LINN BARNES -		ADDRESS 4428 ALTON PLACE, NW WASHINGTON, D.C. 20016			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchial obstruction DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma left lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 d. 5 months 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Metastases to Brain and bone											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1947 , 19 82 , to 1 May , 19 82 , that (1) (we) lost 1 May 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles W. Thompson MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Thompson				22e. ADDRESS 730 - 24th STREET, N.W.-WASH., D.C. 20037							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/2/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, MARYLAND					
24. FUNERAL DIRECTOR'S NAME JOS. GAWLER'S SONS, INC. 5130 WISCONSIN AVE., N.W.-WASHINGTON, D.C.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST GRACE - BARNETTE		2a. DATE OF DEATH MONTH DAY YEAR MAY 15, 1982		2b. HOUR 9:50 P M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 29, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18839 Gaith.Laytonsville Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY Maryland Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 18839 Gaith. Laytonsville Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Irvin - Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Jane Willis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 230-18-3589D		17 INFORMANT ADDRESS Edith Ford Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cancer of the Cervix</u> 1809 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/81	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> , 19____, to <u>1982</u> , 19____, that (I) (we) last saw the deceased alive on <u>5/14/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Susan Withrow</u>		DEGREE MP		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN WITHROW		22e. ADDRESS 15E Deer Park, Gaithersburg					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 19, 1982		23c. NAME OF CEMETERY OR CREMATORY True Gospel		23d. LOCATION Lisbon Howard COUNTY Md. STATE	
24. FUNERAL DIRECTOR FRANCIS H. BARBER				LAYTONSVILLE, MD. 20879		25. DATE RECD. BY REGISTRAR MAY 20 1982	
				26. REGISTRAR'S SIGNATURE Francis H. Barber			

6 1 8 1 5 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 6 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Chester E. BARROWS				MONTH DAY YEAR 5 7 82			
3. SEX Male.				2b. HOUR 6 P.M.			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Chevy Chase				13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7104 Pinehurst Parkway.			
14. FATHER'S NAME FIRST MIDDLE LAST Willis E. Barrows.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Mary Sumner.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.				16b. SOCIAL SECURITY NO. 577-48-0131			
17. INFORMANT ADDRESS Pearl R. Barrows. 13 e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cardiorespiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min 3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5-5 , 19 82 to 5-7 , 19 82 , that (I) was lost saw the deceased alive on 5-7 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
22b. SIGNATURE Thomas G. Sinderson, MD				DEGREE consultant ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-7-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD				22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, Md. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE May 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Rest Cemetery.		23d. LOCATION CITY OR TOWN COUNTY STATE Rest, Va.	
24. FUNERAL DIRECTOR Takoma Funeral Home.				25. DATE REC'D BY REGISTRAR MAY 12 1982			
25a. NAME OF REGISTRAR James G. [Signature]							

BP

Serial. May 12, 1962 West Cemetery. East, Va.

Taxco Funeral Home, Inc. 254 Carroll St. N. W. D. C. 1962

No. 11 Pearl R. Barrows. 13 e.

Willie E. Barrows.

Jennie Mary Sumner.

Maryland. Montgomery. (Gov. Chase.

27194 Pinehurst Parkway.

Feb. Govt. Retired. Police

Vermont. U. S. A.

Male. White. Feb. 17, 1930. No

1 3 1 0 1

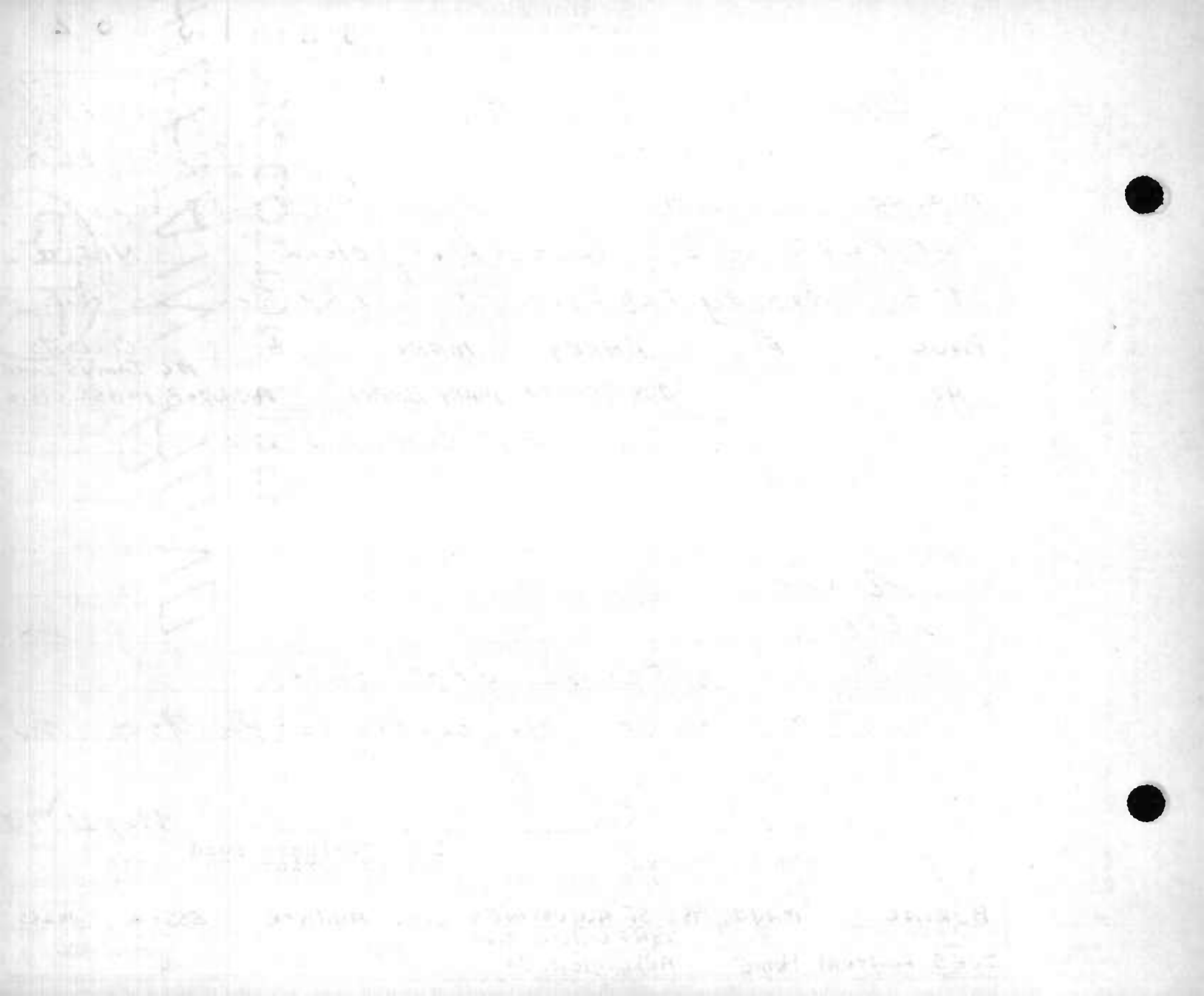
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13162	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LYNN JULIENNA BARRY						2a. DATE KNOWN OF DEATH MONTH DAY YEAR MAY 21 1982		2b. DATE OF DEATH MONTH DAY YEAR MAY 21 1982		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR MAY 21 1982	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR MARCH 25 1932		6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Tak Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
13a. STATE MD 13b. COUNTY Montg. 13c. CITY OR TOWN Tak Park 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 108 Geneva Ave.											
14. FATHER'S NAME FIRST MIDDLE LAST PAUL F. BARRY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. COLLINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 228-78-5302		17. INFORMANT MARY BARRY				ADDRESS #4 TAMYS LANE ANDOVER, MASS. 01810	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 9554 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE OF INJURY UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 521 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Shot self					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Geneva Ave. Tak Park Mont. Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers M.D.						TITLE (SPECIFY) Dep. MEDICAL EXAMINER			DATE SIGNED MAY 21 1982		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers						ADDRESS 1919 Seminary Road Silver Spring, MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 26, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Augustine's Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Andover Essex Mass	
24. FUNERAL DIRECTOR NAME IVES FUNERAL HOME ADDRESS 2847 Wilson Blvd ARLINGTON, VA				25a. DATE REC'D. BY REGISTRAR MAY 1 1982				25b. REGISTRAR'S SIGNATURE James J. [Signature]			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					8 2 1 3 1 6 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Mary Elizabeth Baum					MONTH DAY YEAR May 22, 1982				
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
				MONTH DAY YEAR April 24, 1905		77 YRS		2:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Maryland					13b. COUNTY Mont.		13c. CITY OR TOWN Chevy Chase		
14. FATHER'S NAME JOHN A. GROSE					15. MOTHER'S MAIDEN NAME FANNIE R. CESSNA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 220-28-6111		17. INFORMANT ADDRESS Edith C. Baum, daughter, 300 N. Barton St. Arlington, Va 22201		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>1579</u> <u>METASTATIC CARCINOMA OF PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Status post bilateral radical mastectomy for cancer of breast</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11 May</u> , 19 <u>82</u> , to <u>22 May</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>22 May</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <u>Stephen Edge MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/23/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen Edge MD</u>						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE MAY 23, 1982		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION WASHINGTON, D.C. COUNTY STATE		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D. BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

NAME	ADDRESS	CITY	STATE	ZIP
Mr. J. H. Smith	123 Main St.	Springfield	Ill.	62761
Mr. W. R. Jones	456 Oak Ave.	Chicago	Ill.	60601
Mr. T. L. Brown	789 Elm St.	Peoria	Ill.	61601
Mr. S. K. White	101 Cedar St.	Rockford	Ill.	61101
Mr. M. N. Black	202 Pine St.	Decatur	Ill.	62521
Mr. L. P. Green	303 Maple St.	Normal	Ill.	62451
Mr. K. Q. Red	404 Birch St.	Urbana	Ill.	61501
Mr. J. S. Blue	505 Walnut St.	Macomb	Ill.	61455
Mr. H. T. Yellow	606 Spruce St.	Streator	Ill.	61361
Mr. G. V. Purple	707 Ash St.	LaSalle	Ill.	61301
Mr. F. W. Grey	808 Hickory St.	Marion	Ill.	61751
Mr. D. X. Silver	909 Poplar St.	Shelburne	Ill.	61151
Mr. C. Y. Gold	1010 Sycamore St.	Waukegan	Ill.	60081
Mr. B. Z. Bronze	1111 Chestnut St.	Winnetka	Ill.	60091
Mr. A. W. Iron	1212 Locust St.	Northbrook	Ill.	60061
Mr. R. L. Steel	1313 Walnut St.	Skokie	Ill.	60071
Mr. P. M. Lead	1414 Spruce St.	Wilmette	Ill.	60091
Mr. Q. N. Tin	1515 Birch St.	Winthrop	Ill.	60091
Mr. S. O. Copper	1616 Ash St.	Des Plaines	Ill.	60011
Mr. T. P. Nickel	1717 Hickory St.	Oak Park	Ill.	60451
Mr. U. Q. Zinc	1818 Poplar St.	Itasca	Ill.	60141
Mr. V. R. Silver	1919 Sycamore St.	Westmont	Ill.	60091
Mr. W. S. Gold	2020 Chestnut St.	Northbrook	Ill.	60061
Mr. X. T. Bronze	2121 Locust St.	Skokie	Ill.	60071
Mr. Y. U. Iron	2222 Walnut St.	Wilmette	Ill.	60091
Mr. Z. V. Steel	2323 Spruce St.	Winthrop	Ill.	60091
Mr. A. W. Lead	2424 Birch St.	Des Plaines	Ill.	60011
Mr. B. X. Tin	2525 Ash St.	Oak Park	Ill.	60451
Mr. C. Y. Copper	2626 Hickory St.	Itasca	Ill.	60141
Mr. D. Z. Nickel	2727 Poplar St.	Westmont	Ill.	60091
Mr. E. A. Zinc	2828 Sycamore St.	Northbrook	Ill.	60061
Mr. F. B. Silver	2929 Chestnut St.	Skokie	Ill.	60071
Mr. G. C. Gold	3030 Locust St.	Wilmette	Ill.	60091
Mr. H. D. Bronze	3131 Walnut St.	Winthrop	Ill.	60091
Mr. I. E. Iron	3232 Spruce St.	Des Plaines	Ill.	60011
Mr. J. F. Steel	3333 Birch St.	Oak Park	Ill.	60451
Mr. K. G. Tin	3434 Ash St.	Itasca	Ill.	60141
Mr. L. H. Copper	3535 Hickory St.	Westmont	Ill.	60091
Mr. M. I. Nickel	3636 Poplar St.	Northbrook	Ill.	60061
Mr. N. J. Zinc	3737 Sycamore St.	Skokie	Ill.	60071
Mr. O. K. Silver	3838 Chestnut St.	Wilmette	Ill.	60091
Mr. P. L. Gold	3939 Locust St.	Winthrop	Ill.	60091
Mr. Q. M. Bronze	4040 Walnut St.	Des Plaines	Ill.	60011
Mr. R. N. Iron	4141 Spruce St.	Oak Park	Ill.	60451
Mr. S. O. Steel	4242 Birch St.	Itasca	Ill.	60141
Mr. T. P. Tin	4343 Ash St.	Westmont	Ill.	60091
Mr. U. Q. Copper	4444 Hickory St.	Northbrook	Ill.	60061
Mr. V. R. Nickel	4545 Poplar St.	Skokie	Ill.	60071
Mr. W. S. Zinc	4646 Sycamore St.	Wilmette	Ill.	60091
Mr. X. T. Silver	4747 Chestnut St.	Winthrop	Ill.	60091
Mr. Y. U. Gold	4848 Locust St.	Des Plaines	Ill.	60011
Mr. Z. V. Bronze	4949 Walnut St.	Oak Park	Ill.	60451
Mr. A. W. Iron	5050 Spruce St.	Itasca	Ill.	60141
Mr. B. X. Steel	5151 Birch St.	Westmont	Ill.	60091
Mr. C. Y. Tin	5252 Ash St.	Northbrook	Ill.	60061
Mr. D. Z. Copper	5353 Hickory St.	Skokie	Ill.	60071
Mr. E. A. Nickel	5454 Poplar St.	Wilmette	Ill.	60091
Mr. F. B. Zinc	5555 Sycamore St.	Winthrop	Ill.	60091
Mr. G. C. Silver	5656 Chestnut St.	Des Plaines	Ill.	60011
Mr. H. D. Gold	5757 Locust St.	Oak Park	Ill.	60451
Mr. I. E. Bronze	5858 Walnut St.	Itasca	Ill.	60141
Mr. J. F. Iron	5959 Spruce St.	Westmont	Ill.	60091
Mr. K. G. Steel	6060 Birch St.	Northbrook	Ill.	60061
Mr. L. H. Tin	6161 Ash St.	Skokie	Ill.	60071
Mr. M. I. Copper	6262 Hickory St.	Wilmette	Ill.	60091
Mr. N. J. Nickel	6363 Poplar St.	Winthrop	Ill.	60091
Mr. O. K. Zinc	6464 Sycamore St.	Des Plaines	Ill.	60011
Mr. P. L. Silver	6565 Chestnut St.	Oak Park	Ill.	60451
Mr. Q. M. Gold	6666 Locust St.	Itasca	Ill.	60141
Mr. R. N. Bronze	6767 Walnut St.	Westmont	Ill.	60091
Mr. S. O. Iron	6868 Spruce St.	Northbrook	Ill.	60061
Mr. T. P. Steel	6969 Birch St.	Skokie	Ill.	60071
Mr. U. Q. Tin	7070 Ash St.	Wilmette	Ill.	60091
Mr. V. R. Copper	7171 Hickory St.	Winthrop	Ill.	60091
Mr. W. S. Nickel	7272 Poplar St.	Des Plaines	Ill.	60011
Mr. X. T. Zinc	7373 Sycamore St.	Oak Park	Ill.	60451
Mr. Y. U. Silver	7474 Chestnut St.	Itasca	Ill.	60141
Mr. Z. V. Gold	7575 Locust St.	Westmont	Ill.	60091
Mr. A. W. Bronze	7676 Walnut St.	Northbrook	Ill.	60061
Mr. B. X. Iron	7777 Spruce St.	Skokie	Ill.	60071
Mr. C. Y. Steel	7878 Birch St.	Wilmette	Ill.	60091
Mr. D. Z. Tin	7979 Ash St.	Winthrop	Ill.	60091
Mr. E. A. Copper	8080 Hickory St.	Des Plaines	Ill.	60011
Mr. F. B. Nickel	8181 Poplar St.	Oak Park	Ill.	60451
Mr. G. C. Zinc	8282 Sycamore St.	Itasca	Ill.	60141
Mr. H. D. Silver	8383 Chestnut St.	Westmont	Ill.	60091
Mr. I. E. Gold	8484 Locust St.	Northbrook	Ill.	60061
Mr. J. F. Bronze	8585 Walnut St.	Skokie	Ill.	60071
Mr. K. G. Iron	8686 Spruce St.	Wilmette	Ill.	60091
Mr. L. H. Steel	8787 Birch St.	Winthrop	Ill.	60091
Mr. M. I. Tin	8888 Ash St.	Des Plaines	Ill.	60011
Mr. N. J. Copper	8989 Hickory St.	Oak Park	Ill.	60451
Mr. O. K. Nickel	9090 Poplar St.	Itasca	Ill.	60141
Mr. P. L. Zinc	9191 Sycamore St.	Westmont	Ill.	60091
Mr. Q. M. Silver	9292 Chestnut St.	Northbrook	Ill.	60061
Mr. R. N. Gold	9393 Locust St.	Skokie	Ill.	60071
Mr. S. O. Bronze	9494 Walnut St.	Wilmette	Ill.	60091
Mr. T. P. Iron	9595 Spruce St.	Winthrop	Ill.	60091
Mr. U. Q. Steel	9696 Birch St.	Des Plaines	Ill.	60011
Mr. V. R. Tin	9797 Ash St.	Oak Park	Ill.	60451
Mr. W. S. Copper	9898 Hickory St.	Itasca	Ill.	60141
Mr. X. T. Nickel	9999 Poplar St.	Westmont	Ill.	60091
Mr. Y. U. Zinc	10000 Sycamore St.	Northbrook	Ill.	60061

Respectfully,
[Signature]
[Name]
[Title]
[Address]
[City, State, ZIP]
[Phone Number]
[Fax Number]
[Email Address]
[Web Address]
[Social Media Links]
[Additional Information]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 AE (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Charles Edward Beard

2a. DATE KNOWN OF DEATH

MONTH

DAY

YEAR

2b. HOUR

ESTIMATED

MAY

22

1982

1020

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

Feb 23 33

6. AGE (IN YEARS
LAST BIRTHDAY)

49 YRS.

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

MAY

22

1982

1020

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

10. CITY OR TOWN OF DEATH

Kensington 3018 Plyers Mill Rd

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Military

12b. KIND OF BUSINESS OR INDUSTRY

U.S. Air Force

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Mont.

13c. CITY OR TOWN

Kensington

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3018 Plyers Mill Rd.

14. FATHER'S NAME

Unknown

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Frances

MIDDLE

N.

LAST

Beard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

1954-1974

16b. SOCIAL SECURITY NO.

214-28-5533

17. INFORMANT

ADDRESS

Mrs. Donnis P. Beard, 3018 Plyers Mill Rd. Kensington, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4291

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Acute Myocardial Dis.

(b) Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE
BETWEEN ONSET AND DEATH

Yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Dr. John S. Rogers

TITLE (SPECIFY)

M.D.

Wep

MEDICAL EXAMINER

DATE SIGNED

MAY 22 1982

EXAMINER'S NAME
(TYPE OR PRINT)

Dr. John S. Rogers, M.D.

ADDRESS

1919 Seminary Rd., Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

May 26, 1982

23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

23d. LOCATION
CITY OR TOWN

Frederick, Frederick, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Smith, Keeney and Buford Funeral Home

106 East Church St., Frederick, Md. 21701

25a. DATE REC'D. BY REGISTRAR

MAY 27 1982

25b. REGISTRAR'S SIGNATURE

John S. Rogers

1310 32



... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Roland George Beaulieu			ESTIMATED 5/2/82			11:38 pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		
male	white	MONTH DAY YEAR 8 24 17	64 YRS.	MONTHS DAYS	HOURS MIN	5/2/82 19 11 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Not known		U.S.A		NEVER MARRIED		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park, Md		Washington Adventist Hospital				GROUNDSMAN		GROUNDS
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.			Mont	Takoma Park,	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7600 Maple Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST JOSEPH			FIRST MIDDLE LAST GEORGIANNA DUGAS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			Not available			CAROL J. THURBER, 14301 STURTEVANT RD SS		
18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:								
4149 IMMEDIATE CAUSE (a) Coronary Artery Disease								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
					CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Richard L. Whelton			M.D. Deputy			5-3-82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
RICHARD L. WHELTON			7100 Balt Ave College Park					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			May 5, 1982		George Washington Cemetery		College Park Md	
24. FUNERAL DIRECTOR			25. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
TAKOMA FUNERAL HOME, J. Whelton			MAY 7 1982			Frances Jan Nathan		

1875

Received of
Cash

1875

1875

Received of

1875

1875

1875

Received of

1875

Received of

1875

1875

1875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Earnestine L. Beem			2a. DATE OF DEATH MONTH DAY YEAR May 4, 1982			2b. HOUR 6:15 P. M.			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 3 21 1914		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1229 Cresthaven Drive,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest McCall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Hanlon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS 505-14-8382 Grenville D. Beem-Husband-(same as 13c)					
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c. PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): COLON CANCER 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF LIVER METASTASIS (c) DUE TO, OR AS A CONSEQUENCE OF PULMONARY METASTASIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) the deceased attended the deceased from <u>May 19 77</u> to <u>May 4, 19 82</u> that (ii) he last saw the deceased alive on <u>April 20 19 82</u> and that in (my xxx) opinion death occurred on the date and hour and from the causes stated above, xxx (did I xxx view the body after death.									
22b. SIGNATURE <i>Stephen R. Veach M.D.</i>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 5 May 82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) S.R. VEACH				22f. ADDRESS N.N.M.I., DEPT. MED. ONCOLOGY, BETHESDA, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				24b. ADDRESS 11800 N.H. Ave. s.s. Md.		25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE <i>John W. Nathan</i>	

BP

CONFIDENTIAL
NOV 19 1944

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

July 25

MEMORANDUM FOR THE DIRECTOR, FBI

2. E. VANCE
J. Edgar Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 1 3 1 6 7	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Kurt C. Behrens					2a. DATE OF DEATH MONTH DAY YEAR MAY 27, 1982 7 A M	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		
14. FATHER'S NAME FIRST MIDDLE LAST Karl Behrens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Ulrich		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Sylvia V. Behrens, same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerotic Heart Disease</u> 4 days DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/17/1965</u> to <u>5/27/1982</u> that (I) (we) last saw the deceased alive on <u>5/27/1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Joseph J. Wallace M.D.		DEGREE M.D.		22c. DATE SIGNED May 27, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Wallace M.D.		22e. ADDRESS 5272 River Road, Bethesda, Md. 20816				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		
				25b. REGISTRAR'S SIGNATURE Thomas J. Martin		

BP

10-1-1911

Thompson's Infanterie
Company (Infanterie)

2111

James H. Thompson

10-1-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	8	2	1	3	1	6	8		
1- FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) ESTHER BENDER										2a. DATE OF DEATH		MONTH 5		DAY 27		YEAR 82		2b. HOUR 5 AM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Nov. DAY 6 YEAR 1902			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 74 HRS HOURS MIN. 					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6111 Montrose Road							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson (Ret) Dept. Store			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6111 Montrose Road								
14. FATHER'S NAME FIRST (unknown) MIDDLE LAST 					15. MOTHER'S MAIDEN NAME FIRST (unknown) MIDDLE LAST 														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-07-3212A			17. INFORMANT ADDRESS Brooklyn, N.Y. Edna Naphtale; 20 Bassett Avenue													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy Arrest 4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension & Diabetes Mellitus (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Severe Arthritis, Rheumatoid																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Feb 11 19 82 to March 26 19 82 , that (I) (we) lost saw the deceased alive on March 26 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Howard Goldstein						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/27/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD GOLDSTEIN, MD						22e. ADDRESS 4701 Randolph Road; Rockville, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-30-82			23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.			23d. LOCATION CITY OR TOWN Hyattsville, Md. COUNTY STATE 										
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md.						25. DATE OF RECORD BY REGISTRAR MAY 2 1982													

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 1 3 1 6 9	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Gretchen S Bennett		MONTH DAY YEAR 5/10/82		HOUR 4:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR 7 14 21	60	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	United States		Montgomery County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	Holy Cross Hospital		Homemaker	Home	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	502 Eisner Street
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Edward D. Doubleday		FIRST MIDDLE LAST Edith Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		089 18 5521		Husband Theodore R. Bennett 502 Eisner St. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Dysphagia DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured cerebral aneurysm				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 4 months 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from March 12, 1982, to May 10, 1982, that (I) (we) lost saw the deceased alive on May 10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Raymond Bradshaw, MD				5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Raymond Bradshaw		345 University Blvd, W. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		May 13, 1982	Gate of Heaven		Silver Spring, Maryland
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR	
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				MAY 13 1982	

6 132312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 7 0			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary S. Bennett				2a. DATE OF DEATH MONTH DAY YEAR May 22, 1982		2b. HOUR P 10:25 M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 17 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Wheaton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery Chevy Chase		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Hugh Sheridan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sheridan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 035-30-9099		17. INFORMANT ADDRESS Kathleen B. Larkin same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial failure</u> (c) <u>Coronary atherosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 minutes</u> <u>2 1/2 hrs</u> <u>20 1/2 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Recent stroke, Hypothermia, urinary tract infection</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1974</u> to <u>May 22, 1982</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Stephen Hulburt</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 23, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Stephen Hulburt				22e. ADDRESS 3000 Dent Place Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Church		23d. LOCATION CITY OR TOWN COUNTY STATE Pawtucket Connecticut	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAY 25 1982 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 7 1	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Benita J. Beuchert				2a. DATE OF DEATH MONTH DAY YEAR May 14, 1982 2b. HOUR 3:30 A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 26 1935	
6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12,100 Livingston Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Comm.		13a. STATE Maryland			
13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 12,100 Livingston Street		14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Akers			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Duffy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 577-46-2082		17. INFORMANT Husband Emil E. Beuchert ADDRESS 1102 Holly Lane Holiday, Florida			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lung Disease 5188 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5 14 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased (fill in) on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE David B. Roman, M.D.				22c. DATE SIGNED 5/15/82	
22d. PHYSICIAN'S NAME, (TYPE OR PRINT) David B. Roman, M.D.				22e. ADDRESS 1105 Spring Street Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		24. FUNERAL DIRECTOR Francis J. Collins NAME ADDRESS 500 University Blvd., W. Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE Rene J. [Signature]			

BP

181 S O

181 S O

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1 7 2
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARGARET First Middle Last Billups		2a. DATE OF DEATH Month May Day 2 Year 82		2b. HOUR 1054 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 21, 1907		6. AGE (In years last birthday) 74 YRS.
7a. BIRTHPLACE (State or foreign country) WASH., DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NATIONAL LUTHERAN HOME		9. COUNTY OF DEATH MONTGOMERY CO. Md.
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE VIRGINIA U36. COUNTY PRINCE WILLIAM		13c. CITY OR TOWN LORTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERICAL
14. FATHER'S NAME First CLIFTON Middle F. Last GRAY		15. MOTHER'S MAIDEN NAME First HENRIETTA Middle W. Last BECKSTEDT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-40-5426		17. INFORMANT Address REV. DR. RICHARD REICHARD -NLH - ROCKVILLE, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Cerebral depression DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arteriosclerotic Heart Disease with atrial fibrillation				
19a. DATE OF OPERATION _____	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____		21f. LOCATION Street or R.F.D. No. City or Town County State _____	
22a. I certify that (I) (this hospital) attended the deceased from Jan 28, 1981 to May 2, 1982 , that (I) (we) last saw the deceased alive on May 1, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Harold F. McCann, M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-2-82
22d. PHYSICIAN'S NAME (Type) HAROLD F. MCCANN			22e. ADDRESS 3355-16th St. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 5, 1982	23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.
24. FUNERAL DIRECTOR HYSONG COMPANY - 1300- N ST., NW WASH., DC			25a. REC'D BY REGISTRAR MAY 14 1982	25b. REGISTRAR'S SIGNATURE Harold F. McCann

CERTIFICATE OF DEATH

STATE OF TEXAS

COUNTY OF

CITY OF

DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of

Physician

Signature of

Physician

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

Signature of

Minister of the Gospel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 7 3			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Samuel R Bland				MONTH DAY YEAR May, 23 82				2 ¹⁰ P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 28, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5913 Lone Oak Drive					
14. FATHER'S NAME FIRST MIDDLE LAST Horatio O. Bland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia Richardson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. M 216 44 9377		17. INFORMANT ADDRESS Frances Bland Wife Same as item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebral aneurysm 20 to vent. phlebectasia</u> (c) <u>Cerebral arteriovenous aneurysm</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 10 min 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/15, 19 82, to 5/23, 19 82, the (I) (we) lost saw the deceased alive on 5/23, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE Samuel R. Goldberg MD										22c. DATE SIGNED 5-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel P. Goldberg MD				22e. ADDRESS 11125 Rockville Pike Rockville, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]			

BP

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AARON S. BLAUER			2a. DATE OF DEATH MONTH DAY YEAR 5 26 82		2b. HOUR 6 50 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 - 11 - 15		6. AGE (IN YEARS LAST BIRTHDAY) 67
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive (Ret)		12b. KIND OF BUSINESS OR INDUSTRY G. P. O.
13a. STATE Md. 20783		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN ADELPHI		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Blauer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Blauer		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 11		
17. SOCIAL SECURITY NO. 061-03-7057		18. INFORMANT ADDRESS Gaithersburg, Md. Joseph Blauer; 880 Diamond Drive				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostate Cancer (Metastatic) DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 years 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov 17 19 81 , to May 26 19 82 , that (I) (we) last saw the deceased alive on May 26 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Harvey Katzen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/27/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY KATZEN		DEGREE MD		22e. ADDRESS 6525 Robert Rd Hyattsville, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-30-82		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Md.
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Harvey Katzen

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-11-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 7 5

REG. NO.

1. DECEASED NAME (TYPE PRINT) FIRST MIDDLE LAST Anna Blum			2a. DATE OF DEATH MONTH DAY YEAR 5-9-82			2b. HOUR 7:20 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2 1932		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Messia		7b. CITIZEN OF WHAT COUNTRY? yes (USA)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH M Montgomery MD.			
10. CITY OR TOWN OF DEATH Shiner Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1831 - Shennandoale Dr. AS.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY Homemaker Retired.			
13a. USUAL RESIDENCE (IF HOSPITAL, HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13b. STATE 13c. CITY OR TOWN Phila Pa Phila		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1427 Kenner St.					
14. FATHER'S NAME FIRST MIDDLE LAST Goldberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 166-01-5576		17. INFORMANT ADDRESS Jillie Cronberg - 1831 Shennandoale Dr. AS.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive CVA 4360 DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTAINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NON-ACCIDENTAL <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 3-31-82 19 to 5-9-82 19, that (2) (we) last saw the deceased alive on 4-9-82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles L. Franklin Jr.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-9-82	
22d. PHYSICIAN'S NAME (TYPE PRINT)				22e. ADDRESS 11120 New Hampshire Ave S.W. S.W. 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		May 10 - 1982		H. Lincoln		Blenheim - P. Geo. Md.			
24. FUNERAL DIRECTOR Arthur Keller				25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE 18 1982 James Jan Nathan					

MEDICAL CERTIFICATION

97
90
79
096
39
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 7 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Wallace Bohrer</i>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>May 28, 1982 7:45 M</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 9 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>73 YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>CHEW CHASE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <i>Bethesda Retirement Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>VICE PRES.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FOOD PROCESSING</i>	
13a. STATE <i>MD</i>				13b. COUNTY <i>WASH., D.C.</i>		13c. CITY OR TOWN <i>WASH., D.C.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES BOHRER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY AMELIA DENNER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>578-24-6823</i>		17. INFORMANT ADDRESS <i>MARY LOIS KOFF, 5813 GREENLAWN DR. BETHESDA, MD. 20814</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vascular accident, whether cerebral or coronary</i> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension and other untimely causes</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>Many years</i> <i>many years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>none</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>none</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>none</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>none</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <i>none</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>none</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>none</i>			
22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 1978</i> to <i>April 22 1982</i> , that (I) (we) saw the deceased alive on <i>April 22 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE DEGREE <i>Allen J. O'Neill M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/28/1982</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen J. O'Neill M.D.</i>				22e. ADDRESS <i>8601 Old Georgetown Rd, Bethesda Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6/1/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR NAME <i>JOSEPH CHAWLANTSON, INC. WASHINGTON, D.C.</i>				25a. DATE REC'D. BY REGISTRAR IN REGISTRATION DIVISION <i>May 1982</i>			

BP

43414 10110 X00



[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side. Some words like "CHARGE" and "DATE" are faintly visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13177	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Emmeline</u> MIDDLE <u>Etchison</u> LAST <u>Bowen</u> <u>EMMIE BOWEN</u>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <u>5</u> YEAR <u>1982</u>	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>9</u> DAY <u>13</u> YEAR <u>06</u>	6. AGE (IN YEARS) LAST BIRTHDAY <u>75</u> YRS.	IF UNDER 1 YR. MONTHS <u></u> DAYS <u></u>	IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	2c. DATE PRONOUNCED DEAD <u>5-28</u> 19 <u>82</u>		2d. HOUR <u>10:30</u> P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.					
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>Maryland</u>		13b. CITY OR TOWN <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>9405 Seven Lockes Road</u>			
14. FATHER'S NAME FIRST <u>Emmett</u> MIDDLE <u>---</u> LAST <u>Bowen</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Fannie</u> MIDDLE <u>---</u> LAST <u>Hopper</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mary B. Kremer</u>		ADDRESS <u>9405 Seven Lockes Road Bethesda, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <u>coronary arteriosclerosis</u> (b) <u>years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John Tauber</u>				TITLE (SPECIFY) <u>M.D.</u>				DATE <u>5-28-82</u> SIGNED <u>John Tauber</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tauber</u>				ADDRESS <u>8218 Wisconsin Ave</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-1-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>				23d. LOCATION CITY OR TOWN <u>Shepherdstown</u> COUNTY <u>West Virginia</u> STATE <u>West Virginia</u>			
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Inc.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 3 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John Tauber</u>			
NAME <u>5130 Wisconsin Avenue, N.W.-Washington, D.C.</u>						ADDRESS <u></u>					

1311

82

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar. Page 4 may be retained by the funeral director. Page 5 should be filed in the office of the registrar. Page 6 should be filed in the office of the registrar. Page 7 should be filed in the office of the registrar. Page 8 should be filed in the office of the registrar. Page 9 should be filed in the office of the registrar. Page 10 should be filed in the office of the registrar. Page 11 should be filed in the office of the registrar. Page 12 should be filed in the office of the registrar. Page 13 should be filed in the office of the registrar. Page 14 should be filed in the office of the registrar. Page 15 should be filed in the office of the registrar. Page 16 should be filed in the office of the registrar. Page 17 should be filed in the office of the registrar. Page 18 should be filed in the office of the registrar. Page 19 should be filed in the office of the registrar. Page 20 should be filed in the office of the registrar. Page 21 should be filed in the office of the registrar. Page 22 should be filed in the office of the registrar. Page 23 should be filed in the office of the registrar. Page 24 should be filed in the office of the registrar. Page 25 should be filed in the office of the registrar. Page 26 should be filed in the office of the registrar. Page 27 should be filed in the office of the registrar. Page 28 should be filed in the office of the registrar. Page 29 should be filed in the office of the registrar. Page 30 should be filed in the office of the registrar. Page 31 should be filed in the office of the registrar. Page 32 should be filed in the office of the registrar. Page 33 should be filed in the office of the registrar. Page 34 should be filed in the office of the registrar. Page 35 should be filed in the office of the registrar. Page 36 should be filed in the office of the registrar. Page 37 should be filed in the office of the registrar. Page 38 should be filed in the office of the registrar. Page 39 should be filed in the office of the registrar. Page 40 should be filed in the office of the registrar. Page 41 should be filed in the office of the registrar. Page 42 should be filed in the office of the registrar. Page 43 should be filed in the office of the registrar. Page 44 should be filed in the office of the registrar. Page 45 should be filed in the office of the registrar. Page 46 should be filed in the office of the registrar. Page 47 should be filed in the office of the registrar. Page 48 should be filed in the office of the registrar. Page 49 should be filed in the office of the registrar. Page 50 should be filed in the office of the registrar. Page 51 should be filed in the office of the registrar. Page 52 should be filed in the office of the registrar. Page 53 should be filed in the office of the registrar. Page 54 should be filed in the office of the registrar. Page 55 should be filed in the office of the registrar. Page 56 should be filed in the office of the registrar. Page 57 should be filed in the office of the registrar. Page 58 should be filed in the office of the registrar. Page 59 should be filed in the office of the registrar. Page 60 should be filed in the office of the registrar. Page 61 should be filed in the office of the registrar. Page 62 should be filed in the office of the registrar. Page 63 should be filed in the office of the registrar. Page 64 should be filed in the office of the registrar. Page 65 should be filed in the office of the registrar. Page 66 should be filed in the office of the registrar. Page 67 should be filed in the office of the registrar. Page 68 should be filed in the office of the registrar. Page 69 should be filed in the office of the registrar. Page 70 should be filed in the office of the registrar. Page 71 should be filed in the office of the registrar. Page 72 should be filed in the office of the registrar. Page 73 should be filed in the office of the registrar. Page 74 should be filed in the office of the registrar. Page 75 should be filed in the office of the registrar. Page 76 should be filed in the office of the registrar. Page 77 should be filed in the office of the registrar. Page 78 should be filed in the office of the registrar. Page 79 should be filed in the office of the registrar. Page 80 should be filed in the office of the registrar. Page 81 should be filed in the office of the registrar. Page 82 should be filed in the office of the registrar. Page 83 should be filed in the office of the registrar. Page 84 should be filed in the office of the registrar. Page 85 should be filed in the office of the registrar. Page 86 should be filed in the office of the registrar. Page 87 should be filed in the office of the registrar. Page 88 should be filed in the office of the registrar. Page 89 should be filed in the office of the registrar. Page 90 should be filed in the office of the registrar. Page 91 should be filed in the office of the registrar. Page 92 should be filed in the office of the registrar. Page 93 should be filed in the office of the registrar. Page 94 should be filed in the office of the registrar. Page 95 should be filed in the office of the registrar. Page 96 should be filed in the office of the registrar. Page 97 should be filed in the office of the registrar. Page 98 should be filed in the office of the registrar. Page 99 should be filed in the office of the registrar. Page 100 should be filed in the office of the registrar.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 7 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MARY		MAY 7, 1982		8 AM	
MIDDLE T.					
LAST BOREN					
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		JAN 18, 1905	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
NEBRASKA		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
ROCKVILLE		POTOMAC VALLEY NURSING HOME		MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
		W & L			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		MONTGOMERY		SILVER SPRING	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
IRA TALBOT		FLORENCE GREENMYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		579-22-2268		DAUGHTER	
				ADDRESS	
				9924 JULLIARD DRIVE	
				BETHESDA, MD. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Sepsis</u>					
4402					
DUE TO, OR AS A CONSEQUENCE OF					
b) <u>Craniopharyngioma of 1cg</u>				2 months	
DUE TO, OR AS A CONSEQUENCE OF					
c) <u>Atherosclerosis</u>				5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
<u>Polycythemia Vera, Organic Brain Syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>July 4/82</u> 19 <u>82</u> to <u>5/7</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>4/30</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (and) not view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		DEGREE			
		M.D.		5/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Peter Sherer MD		1109 Spring St. Silver Spring MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		5/10/82		PARKLAWN CEMETERY	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		MAY 13 1982	
				25b. REGISTRAR'S SIGNATURE	
				Name J. Smith	

1 2 1 1 9

8 5

THE UNIVERSITY OF CHICAGO
LIBRARY

2 X

(10)

NOT
TO
BE
REPRODUCED

(15)

NOT
TO
BE
REPRODUCED

(16)

X-1000

%

LIBRARY

Cleared by Medical Examiner, Dr. Rogers - 8-1-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 7 9	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVA G. BOWMAN			2a. DATE OF DEATH MONTH DAY YEAR May 21 1982		2b. HOUR 0:58a.m.
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR October 14, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Robey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roseamay Pilkerton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-22-3703		17 INFORMANT Gene C. Bowman	
				ADDRESS Address Same as No# 13c.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151 MASSIVE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from 5/21 19 82 , to 5/21 19 82 , that (I (we) last saw the deceased alive on 5/21 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, ((we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry N. Rosenbaum, M.D.		DEGREE M.D.		22c. DATE SIGNED 5/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM		22e. ADDRESS 3720 FARRAGOT AVE. KENSINGTON, MD. 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-25-82		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Va.					
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.				DATE REC'D. BY REGISTRAR MAY 25 1982	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Edith Towson Boyce		STATE OF MARYLAND	
1 - FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH		REG. NO. 8 2 1 3 1 8 0	
1. DECEASED NAME (TYPE OR PRINT) EDITH Towson BOYCE		2a. DATE OF DEATH MONTH 5 DAY 4 YEAR 82 2b. HOUR 2:08 PM	
3. SEX F	4. RACE Caucas.	5. DATE OF BIRTH MONTH 3 DAY 24 YEAR 96	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN US, GIVE STREET ADDRESS) Robert Cross Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired National Geographic	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Silver Spring	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f. STREET ADDRESS 714 Richmond Ave.	
14. FATHER'S NAME FIRST Derrey MIDDLE G. H. LAST Towson	15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE Campbell LAST Blanche	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. 579-48-8086		17. INFORMANT John W. Kew ADDRESS 1010 - 16th St. N.W. DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) HEART ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/3 82	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/3 82 to 5/4 82 , that (I) (we) lost 5/4 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Kenny Bisk MD DEGREE MD		22c. DATE SIGNED 5/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNY BISK MD		22e. ADDRESS 8630 FENTON ST SILVER SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial	23b. DATE May 7-1982	23c. NAME OF CEMETERY OR CREMATORY Cath Hill	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR John W. Kew		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John W. Kew	

BP

1883

Edith Towson Boyce

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

Items 13a-e per phone 6/14/82 date of Maryland
 FOR
 1 - STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BENJAMIN PAUL BREAUT			2a. DATE OF DEATH MONTH DAY YEAR MAY 25, 1982		2b. HOUR 4:40 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 25 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a		12b. KIND OF BUSINESS OR INDUSTRY n/a
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N. C.		13b. COUNTY Jacksonville	13c. CITY OR TOWN Jacksonville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RANDALL PAUL BREAUT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOAN MAY CARR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JACKSONVILLE, NC RANDALL P. BREAUT, 318 #2 RICHLAND AVE.,	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7599 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congenital skeletal dysplasia DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 25, 1982 to MAY 25, 1982 , that (I) (we) last saw the deceased alive on MAY 25, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James W. Thorp MD		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES THORP, CDR, MC, USN		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-29-82	23c. NAME OF CEMETERY OR CREMATORY Summer Street	23d. LOCATION CITY OR TOWN COUNTY STATE Lancaster, Coos, N. H.
24. FUNERAL DIRECTOR NAME W. W. Chambers Co, 8655 Georgia Ave, Sil. Sp		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 1982	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Joseph B. Brennan			2a DATE OF DEATH MONTH DAY YEAR May 26, 1982			2b HOUR 3:40p M			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 4 24 1900		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 82	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY SOUTHERN RAILWAY	
13a STATE MD.			13b COUNTY Montgomery		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN T. BRENNAN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. KELLY			13e STREET ADDRESS 1002 CLIFTON BROOK LANE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 718-10-6227		17 INFORMANT ADDRESS GERTRUDE C. BRENNAN SAME AS 13 WIFE				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4392 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from March 31 , 19 82 , to May 26 , 19 82 , that (I) (we) last saw the deceased alive on May 25 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not know the exact date of death.									
22b SIGNATURE THOMAS E. DOOLEY					22c. DATE SIGNED MAY 26 1982			22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOOLEY	
22e ADDRESS OLNEY MARYLAND					22f. ADDRESS OLNEY MARYLAND				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 5/29/82		23c NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.		
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Ramon J. [Signature]		
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

400
Q100A



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 1 8 3
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE R. LAST BRENNER			2a DATE OF DEATH MONTH 5 DAY 13 YEAR 82			2b HOUR M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH MAY DAY 28 YEAR 1934		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co. Government		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.				13b COUNTY Montgomery		13c CITY OR TOWN COMUS	
14 FATHER'S NAME FIRST MAX MIDDLE W. LAST Rickard				15. MOTHER'S MAIDEN NAME FIRST HELNA MIDDLE WALSH LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-1210		17 INFORMANT ADDRESS Mr. BRENNER Pickersole Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGEAL NECROSIS 1729 DUE TO, OR AS A CONSEQUENCE OF (b) MELANOMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/13 19 82, to 5/13 19 82, that (I) (we) last saw the deceased alive on 5/13 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel Rosenberg		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM, M.D.		22e. ADDRESS 10400 CANN AVE, KENSINGTON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS		23d. LOCATION CITY OR TOWN COUNTY STATE Dorseyville Montgomery Md.	
24 FUNERAL DIRECTOR NAME Ducyfelt		24b. ADDRESS Brennert Rd.		25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE	

35
70
35
160
1
1
1
1

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1. FOR STATE REGISTRAR					7. DATE OF DEATH MONTH DAY YEAR	
1. DECEASED NAME FIRST MIDDLE LAST Helen M BRESLER					7. DATE OF DEATH MONTH DAY YEAR MAY 23 82	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 20 23		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		
14. FATHER'S NAME FIRST MIDDLE LAST David Messerman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertie Beckman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 104-16-3670		17. INFORMANT ADDRESS Chevy Chase, Md. Elliott Bresler; 3309 Glenmoor Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 1579 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pancreatic Cancer</u> 1 1/2 yrs. (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 5/12/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DUODENAL OUTLET OBST. / CA PANCREAS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Aron Primack		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARON PRIMACK		22e. ADDRESS 106 IRVING ST. N.W. WASHINGTON				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-25-82		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		
23d. LOCATION CITY OR TOWN Olney, Maryland		23e. COUNTY Rockville, Md.		23f. STATE Danzansky-Goldberg Chapels; 1170 Rockville Pike		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE Anne G...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 8 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL H. BRESLER				2a. DATE OF DEATH MONTH DAY YEAR May 27, 1982		2b. HOUR 3:15p_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1902		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pres. (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Poultry Co.	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Bresler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Brownstein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 182-05-2927		17. INFORMANT ADDRESS Charles Bresler; 3217 Farmington Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes - Previous Myocardial Infarcts							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/14 P.M. 19 58		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (1) (the hospital) attended the deceased from 5/27 19 82 , to 5/27 19 82 , that (1) (we) lost saw the deceased alive on 5/27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body at death, so state.)		21h. SIGNATURE DEGREE Herbert L. Tanenbaum M.D.	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT L. TANENBAUM, M.D.		22b. ADDRESS 5480 Wisconsin Ave., Chevy Chase, Md.		22c. DATE SIGNED 5-27-82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/30/82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;		24b. ADDRESS 1170 Rockville Pike		25. DATE REC'D. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

[Faint, illegible text, likely bleed-through from the reverse side of the page]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) ANN ELIZABETH BRIDGES					2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1982					2b. HOUR 6:00 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 24 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9207 SHELTON STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9207 SHELTON STREET		
14. FATHER'S NAME HENRY ALBERT BRIDGES				15. MOTHER'S MAIDEN NAME ELIZABETH ANN JACKSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 172-07-3778-D (577-84-5159)		17. INFORMANT ADDRESS MRS. MARIAN B. CARTER BETHESDA, MD. 20817					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Road Fatigue</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Dehydration</u> (c) <u>Cerebral anoxia of Colon</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary Heart Disease</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 26</u> , 19 <u>77</u> , to <u>May 7</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>March 8</u> , 19 <u>82</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <u>Harris W. Kenner</u>				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRIS W. KENNER MD				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda Md 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 11, 82		23c. NAME OF CEMETERY OR CREMATORY JEFFERSON MEMORIAL			23d. LOCATION McKEESPORT COUNTY PA.		
24. FUNERAL DIRECTOR NAME R&R FUNERAL SERVICES, 3520 CONN. AVE., NW, D.C.				DATE RECEIVED BY REGISTRAR MAY 13 1982				REGISTRAR SIGNATURE <u>[Signature]</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

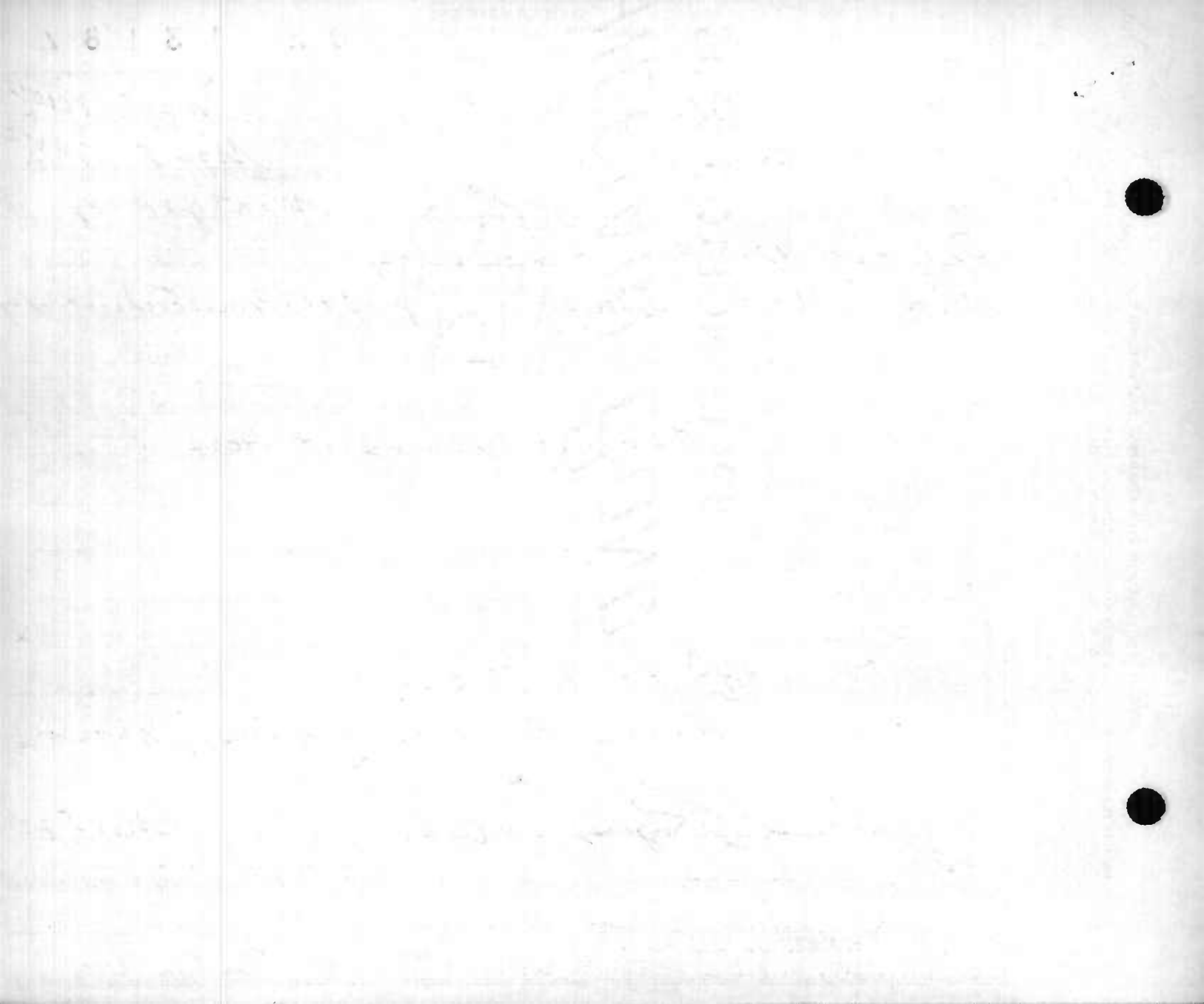
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>William Solomon Brinsfield</i>			2a. DATE KNOWN OF DEATH ESTIMATED <i>May 5, 1982</i>			2b. HOUR OF DEATH <i>2:10 PM</i>		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 12 04 77</i>	6. AGE IN YEARS (LAST BIRTHDAY) <i>77</i> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>May 5, 1982</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Sil. Spg</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>15403 Prince Frederick Way</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PHARMACIST</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SELF EMPLOYED</i>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Sil. Spg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>GEORGE BRINSFIELD</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MAUDE HARRIS</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		
16b. SOCIAL SECURITY NO. <i>220-01-9884</i>			17. INFORMANT <i>KATHRYN S. BRINSFIELD</i>			ADDRESS <i>SAME AS 13 WIFE</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wound of Head</i> 9554 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>None</i>								
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>9:15 P.M. 5 5 1982</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Shot self</i>			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Prince Frederick Way, Sil. Spg, Mont MD</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquest <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) <i>Dep.</i>			DATE SIGNED <i>May 5, 82</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>			ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5/7/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND PRI GEO MD.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 13 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 1 8 8	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN BROOKS						2a. DATE OF DEATH MONTH DAY YEAR 5/5/82			2b. HOUR 3:30 PM		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 05 96		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. 4 0		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (COUNTRY) St. Mary's Co. MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring BEL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRE HEALTH CARE CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. COUNTY		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1224 HOLBROOK ST. N.E.			
14. FATHER'S NAME FIRST MIDDLE LAST Unk.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1918-1919		17. INFORMANT Registrary of VA Hospital, D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 YRS. 4 YRS.	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Diabetes Mellitus, Hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. now, the deceased alive on May 4 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE R. T. Benack MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/5/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. Benack MD				22e. ADDRESS 4115 Colie Drive, Wheaton, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-82		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION CUTPEPPER, VA. STATE					
24. FUNERAL DIRECTOR NAME Johnson & Jenkins F.H.				ADDRESS 716 Kennedy St. N.W., D.C.				25a. DATE REC'D. BY REGISTRAR MAY 19 1982			

08/21 304

08/22 305

08/23 306

08/24 307

08/25 308

08/26 309

08/27 310

08/28 311

08/29 312

08/30 313

08/31 314

09/01 315

09/02 316

09/03 317

09/04 318

09/05 319

08/21 304

08/22 305

08/23 306

08/24 307

08/25 308

08/26 309

08/27 310

08/28 311

08/29 312

08/30 313

08/31 314

09/01 315

09/02 316

09/03 317

09/04 318

09/05 319

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13189

1. DECEASED NAME (TYPE OR PRINT) Team Doris Brown			2a. DATE KNOWN OF DEATH ESTIMATED May 17, 1982			2b. HOUR 8:00		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 26 24 57	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD May 19, 1982	7d. HOUR 1:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13304 Artie Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian assistant		
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Archibald S. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Moe		16. SOCIAL SECURITY NO. 126-14-0411				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 126-14-0411		17. INFORMANT Donald J. Brown				
16c. ADDRESS Falls Church, Va.		16d. ADDRESS 809 West Broad St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 620 train tect, nial Hemorrhage 5789 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED May 19, 1982		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Seminary Road Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE James J. Martin		
ADDRESS 1331 Rockville Pike Rockville, Maryland								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, BEFORE EXECUTING THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1935 - 1936
1937 - 1938
1939 - 1940
1941 - 1942
1943 - 1944
1945 - 1946
1947 - 1948
1949 - 1950
1951 - 1952
1953 - 1954
1955 - 1956
1957 - 1958
1959 - 1960
1961 - 1962
1963 - 1964
1965 - 1966
1967 - 1968
1969 - 1970
1971 - 1972
1973 - 1974
1975 - 1976
1977 - 1978
1979 - 1980
1981 - 1982
1983 - 1984
1985 - 1986
1987 - 1988
1989 - 1990
1991 - 1992
1993 - 1994
1995 - 1996
1997 - 1998
1999 - 2000
2001 - 2002
2003 - 2004
2005 - 2006
2007 - 2008
2009 - 2010
2011 - 2012
2013 - 2014
2015 - 2016
2017 - 2018
2019 - 2020
2021 - 2022
2023 - 2024
2025 - 2026
2027 - 2028
2029 - 2030
2031 - 2032
2033 - 2034
2035 - 2036
2037 - 2038
2039 - 2040
2041 - 2042
2043 - 2044
2045 - 2046
2047 - 2048
2049 - 2050
2051 - 2052
2053 - 2054
2055 - 2056
2057 - 2058
2059 - 2060
2061 - 2062
2063 - 2064
2065 - 2066
2067 - 2068
2069 - 2070
2071 - 2072
2073 - 2074
2075 - 2076
2077 - 2078
2079 - 2080
2081 - 2082
2083 - 2084
2085 - 2086
2087 - 2088
2089 - 2090
2091 - 2092
2093 - 2094
2095 - 2096
2097 - 2098
2099 - 2100

John A. Jones

Springfield, Mass.

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 1 9 0
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LELAND S. BROWN			2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1982			2b. HOUR 6:30 a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5806 Ogden Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas --- Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belle --- Johnson			16. SOCIAL SECURITY NO. 577-36-8511			
17. INFORMANT Audrey B. Hildebrand			ADDRESS 5806 Ogden Court Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Cardio-Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Broncho-pneumonia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1978 , 19 5-4 , 1982, that (I) (we) last saw the deceased alive on 5-3-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Russell M. Tilley, Jr. MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5-4-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, M.D.						22e. ADDRESS 4701 Massachusetts Ave., N.W.-Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-6-82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem'l. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Jos. Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 10 1982	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

31 x 8

8

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible handwritten text]

[Illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 1 9 1	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL BRUNER						2a. DATE OF DEATH MONTH DAY YEAR 5 26 82		2b. HOUR 10:56 AM			
1. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 5 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA. 13b. COUNTY MERCER 13c. CITY OR TOWN GROVE CITY 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 527 So. Center St.					
14. FATHER'S NAME FIRST MIDDLE LAST EARLE DANIEL BRUNER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA BELLE MOON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 193-10-2153		17. INFORMANT LEONARD BRUNER		ADDRESS 10315 Haywood Dr. Wheaton, Md. 20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 2 MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1/19/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 81 to 9/26 19 82 , that (I) (we) lost saw the deceased alive on 8/26 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) do the body after death.											
22b. SIGNATURE Arnold G. Levy		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-26-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arnold G. Levy		M.D.		22e. ADDRESS 1106 SPRING ST., SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Burial)		23b. DATE 5-29-82		23c. NAME OF CHURCH OR PRESTBY. North United Presby. Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Plaingrove Pennsylvania					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home ADDRESS Rockville Md. 20852 DATE REC'D. BY REGISTRAR MAY 28 1982 REGISTRAR'S SIGNATURE Frances Jan Nathan											

13191 82

Montgomery Co.

SALES TAX DEPARTMENT

STATE OF MARYLAND

NO

North United Property

Statewide Pennsylvania

Office of the

Department of the

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 9 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FLORENCE LILLIAN BRYAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 25, 1982			7b. HOUR 10:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 04 00		6. AGE (IN YEARS LAST BIRTHDAY) 81			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. CITY OR TOWN Montg. Gaithersburg		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 813 Diamond Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Wilson H. Lucas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Absay Isabelle Lucas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 243-30-0586		17. INFORMANT Clyde M. Bryan, Jr., Son, Same as item #13				
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Congestive cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive Pulmonary Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) Chronic Bronchitis									
19a. DATE OF OPERATION 5/25/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive Pulmonary Disease			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/25/82 8:25 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1811 Prince Philip Drive Olney, Maryland 20832					
22a. I certify that (I) (this hospital) attended the deceased from 5/25/82 to 5/25/82 , that (I) (we) last saw the deceased alive on 5/25/82 19 82 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Charles H. Ligon, M.D.				DEGREE M.D.		22c. DATE SIGNED 5/25/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Ligon, M.D.				22e. 1811 Prince Philip Drive Olney, Maryland 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Montlawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Raleigh, North Carolina			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

3135

03

100

200

200

Handwritten notes in cursive script, possibly a list or journal entry.

Handwritten text in cursive script, possibly a signature or a heading.

2/12

2

2/12

2/12

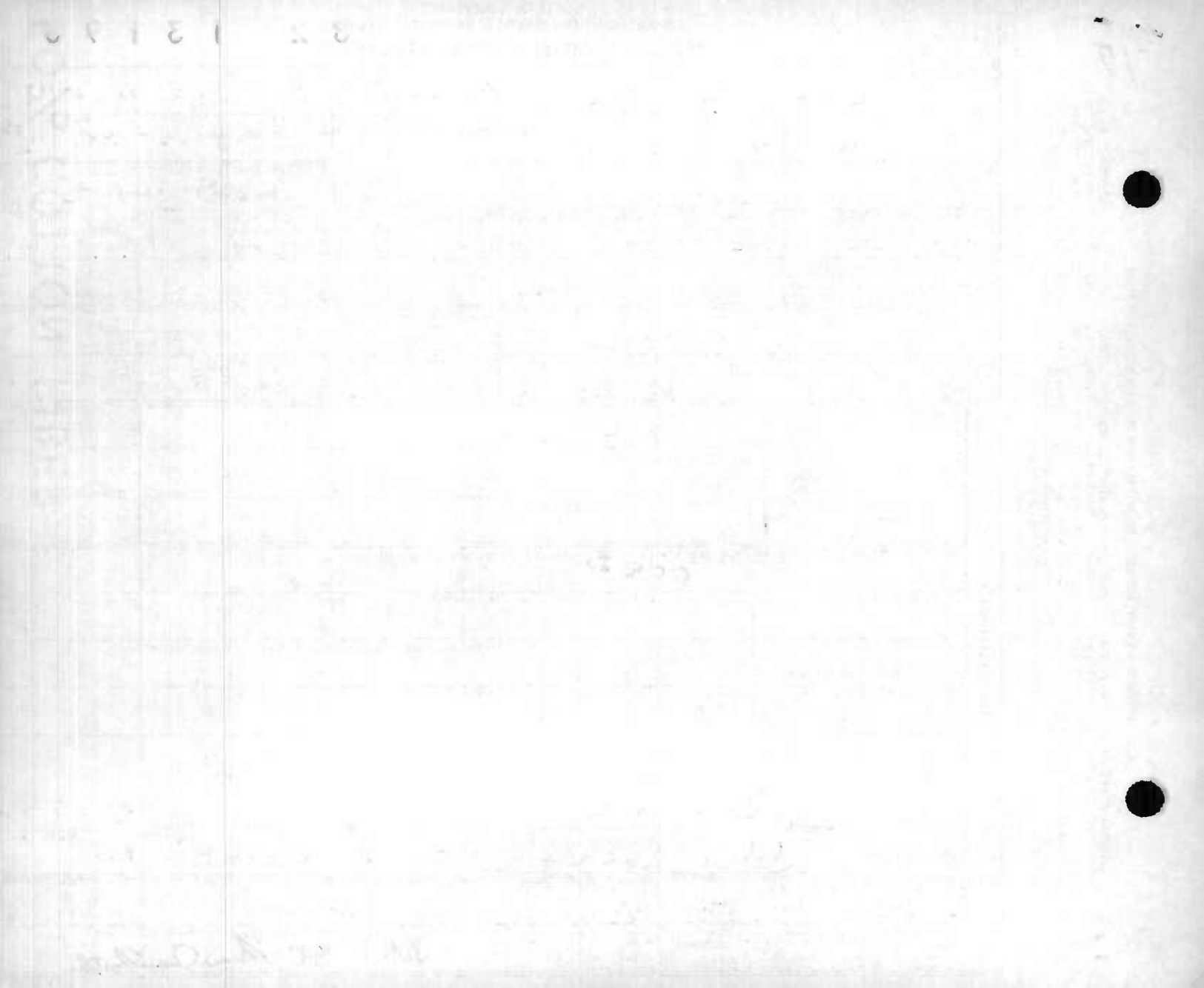
Handwritten signature or name in cursive script.

Handwritten text at the bottom of the page, possibly a date or a reference.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13193			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Elsa Dorothy Bryant			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR 5 25 82		2b. HOUR 11:55 A.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 5 08		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 5 - 25 82 19		2d. HOUR 11:55 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5480 Wisconsin Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5480 Wisconsin Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Walter E. Bryant						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Tibbetts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 016-12-2632		17. INFORMANT ADDRESS 205 Prospect St. Marilyn B. Goddard Hingham, Mass.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). COED												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <u>John Toubert</u> M.D.						TITLE (SPECIFY) MEDICAL EXAMINER			DATE SIGNED 5-25-82				
EXAMINER'S NAME (TYPE OR PRINT) John Toubert						ADDRESS 8218 Wisconsin Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 28, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 1 1982			25b. REGISTRAR'S SIGNATURE Anne Jan Martin				

BP



1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
Wilton Lee Bryant		Lee		May 17 1982		May 17 1982		526 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M	W	Dec 12 1944	37 YRS.	MONTHS DAYS		HOURS MIN.		May 17 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U. S. A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Sil. Spr.		Holy Cross Hosp				Farmer-Retired Farming			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Mont		Sil. Spr.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1913 Luzerne Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Columbus T. Bryant		Laura A. Sisson		No		213-24-8808		George W. Bryant Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292				Renal Failure					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		Arterio sclerotic cardiovascular Dis. and Hemolytic Anemia			
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
Fracture Rt. Hip									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
5-5-82		Fracture Rt. Hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 4 23 1982		Fall at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY/TOWN COUNTY STATE					
		Home		Luzerne Ave, Sil. Spr., Mont. MD.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
John S. Rogers, M.D.		DME		May 17, 1982					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
John S. Rogers		Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/20/82		Ft. Lincoln Cemetery		Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Howard E. Pumphrey, Inc.		MAY 20 1982		James J. Nathan					
Warner E. Pumphrey, Inc.		Sil. Spr., Md.							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 1 9 5

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN T. BUCKLEY			2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1982		2b. HOUR 12:02 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 28, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 728 DENNIS AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 728 DENNIS AVENUE 20901
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN BUCKLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 577-38-2201		17. INFORMANT ADDRESS LORRAINE M. BUCKLEY SAME AS 13 WIFE	
18. CAUSE OF DEATH: Enter only one cause pending for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, sigmoid, with 1533 DUE TO, OR AS A CONSEQUENCE OF generalized metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Undeterm.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None.					
19a. DATE OF OPERATION 3/19/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MA		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 70 to May 1 82 , that (I) (we) last saw the deceased alive on Apr 20 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE William F. Simpson, MD		DEGREE		22c. DATE SIGNED 5/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Simpson, MD		22e. ADDRESS 8106 N.H. Ave Silver Spring Md 20903			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/5/82	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR MAY 6 1982		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25b. REGISTRAR'S SIGNATURE Thomas Van Winkle		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-335-1500.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 1 9 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY J. BURCKBUCHER			2a. DATE OF DEATH MONTH DAY YEAR May 15 '82 12:30 A	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 30, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE New Jersey	13b. COUNTY Rockaway	13c. CITY OR TOWN Rockaway	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Joseph Burckbuchler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara - Munz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.II 042-14-4458		17. INFORMANT ADDRESS Frederick Burckbuchler (Son) Same as # 13.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) 3d 4100				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR March 19 78		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from March 19 78 to May 15 19 82 , that (I) (we) lost saw the deceased alive on May 13 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)		
22b. SIGNATURE John F. Gustafson		DEGREE M.D.		22c. DATE SIGNED 15 May 82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Gustafson, M.D.		22e. ADDRESS 5480 Wisconsin Avenue Chevy Chase, Md. 20815		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY 17, 1982	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETORY	
23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. CO. MARYLAND		24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		
24b. ADDRESS SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR MAY 19 1982		

MEDICAL CERTIFICATION

Henry I Burckbacher

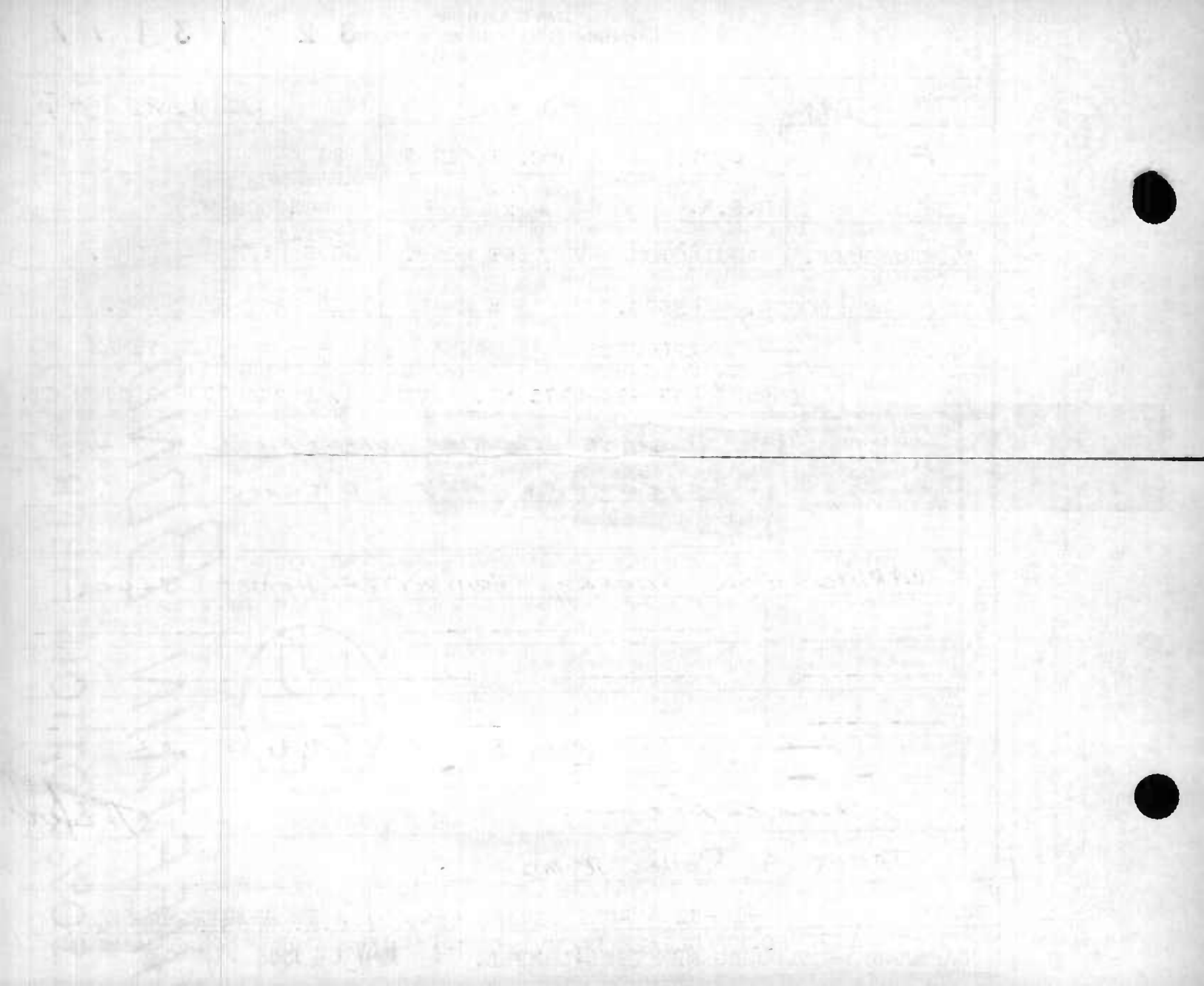
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove early papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 2 1 3 1 9 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>Ida</i> FIRST MIDDLE LAST <i>Burka</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>05 12 82</i>			2b. HOUR <i>545p</i> M.		
1. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>DEC. 16 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.				
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSP.</i>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOME.</i>		
13a. STATE <i>MD</i>					13b. COUNTY <i>MONTG.</i>		13c. CITY OR TOWN <i>SSPG.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>MAX --- KAPLOWITZ</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA --- PRESSMAN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>NO</i>					16b. SOCIAL SECURITY NO <i>579-14-8175</i>		17. INFORMANT ADDRESS <i>MR. IRVING A. BURKA 7739 ROCTON CT.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4100</i> <i>Acute MYOCARDIAL INFARCTION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>CORONARY ART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 HRS</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>CARDIOGENIC SHOCK; COMPLETE HEART BLOCK</i>										
19a. DATE OF OPERATION <i>---</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>---</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. --- 19 82</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>---</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>---</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>---</i>				
22. I certify that (1) this hospital attended the deceased from <i>MAY 12 19 82</i> to <i>MAY 12 19 82</i> , that (1) (we) last saw the deceased alive on <i>MAY 12 19 82</i> and that in (my) opinion death occurred on the date and hour and from the causes stated										
22a. SIGNATURE <i>James A. Roman</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/12/82</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES A. ROMAN JR, MD</i>			22e. ADDRESS <i>---</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>5-14-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ADAS ISRAEL CEM.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>S.E. WASHINGTON D.C.</i>		
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPEL.</i>			1170 ROCKVILLE PK ROCKVILLE MD			25a. DATE REC'D BY REGISTRAR <i>MAY 14 1982</i>				



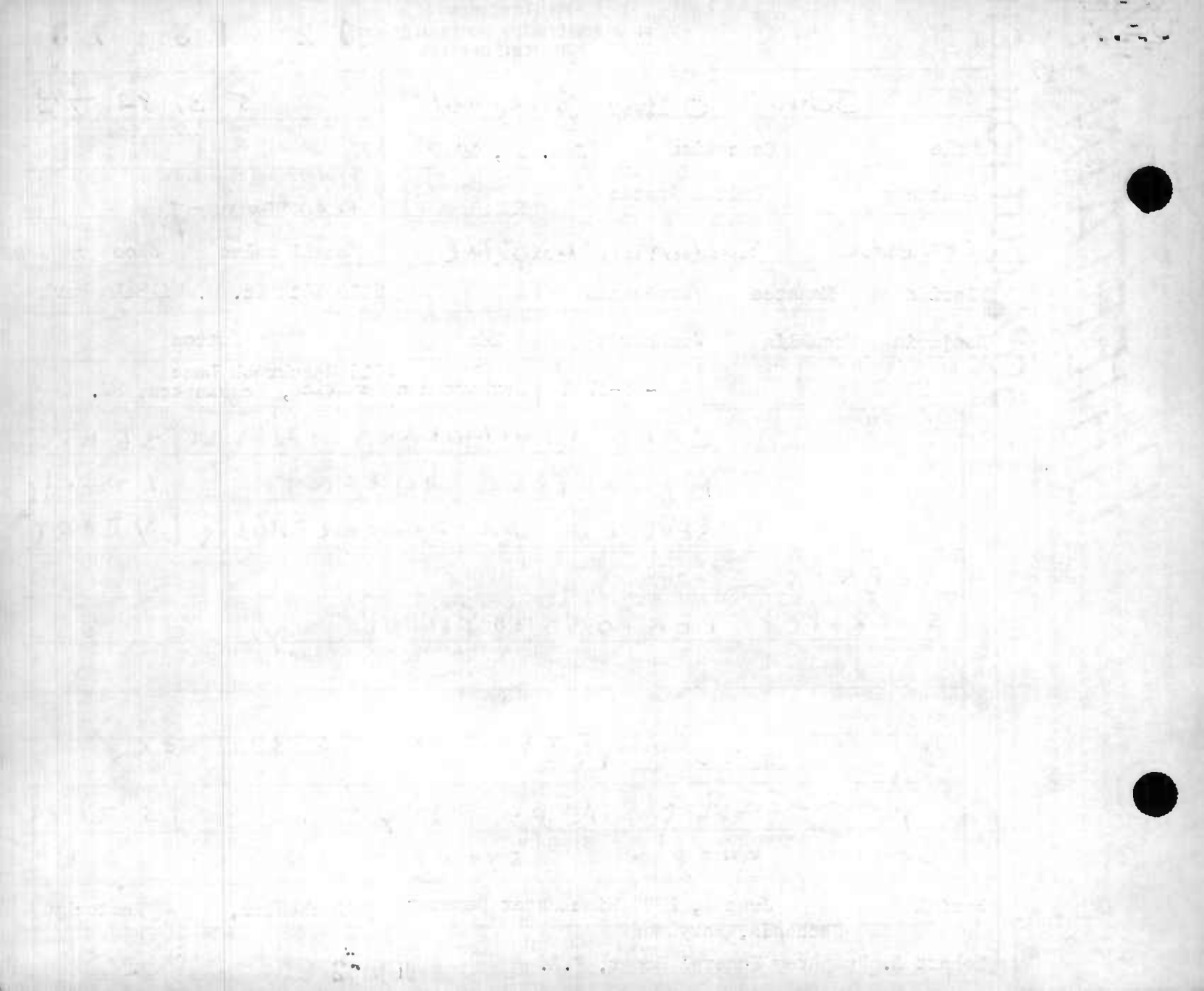
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 1 9 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST John O liver Burkhardt				MONTH DAY YEAR HOUR 5 31 82 7 ⁴⁰ AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		Jan. 31, 1905		77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Kentucky		United States				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		Retail sales		Shoe	
13a. STATE				13b. STREET ADDRESS			
Florida				6330 14th St. W. Wilhelm Park			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Benjamin Franklin Burkhardt				FIRST MIDDLE LAST Ida Sutton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
NO				404-09-6742			
17. INFORMANT				4313 Westbrook Lane Barbara Ann Kendrick, Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE							
4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCT							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE ARTEROSCLEROSIS							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours 1 week YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SEPSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
5-28-82		PERFORATED COLON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-28-82, 1982, to 5-31-82, 1982 that (I) (we) lost saw the deceased alive on 5-30-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				5-31-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
BENNY KREUTZ				541 CEDAR LN BETHA. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		June 4, 1982		Winchester Cemetery		Winchester, COUNTY Kentucky	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A.				25b. REGISTRAR'S SIGNATURE JUN 2 1982			

BP



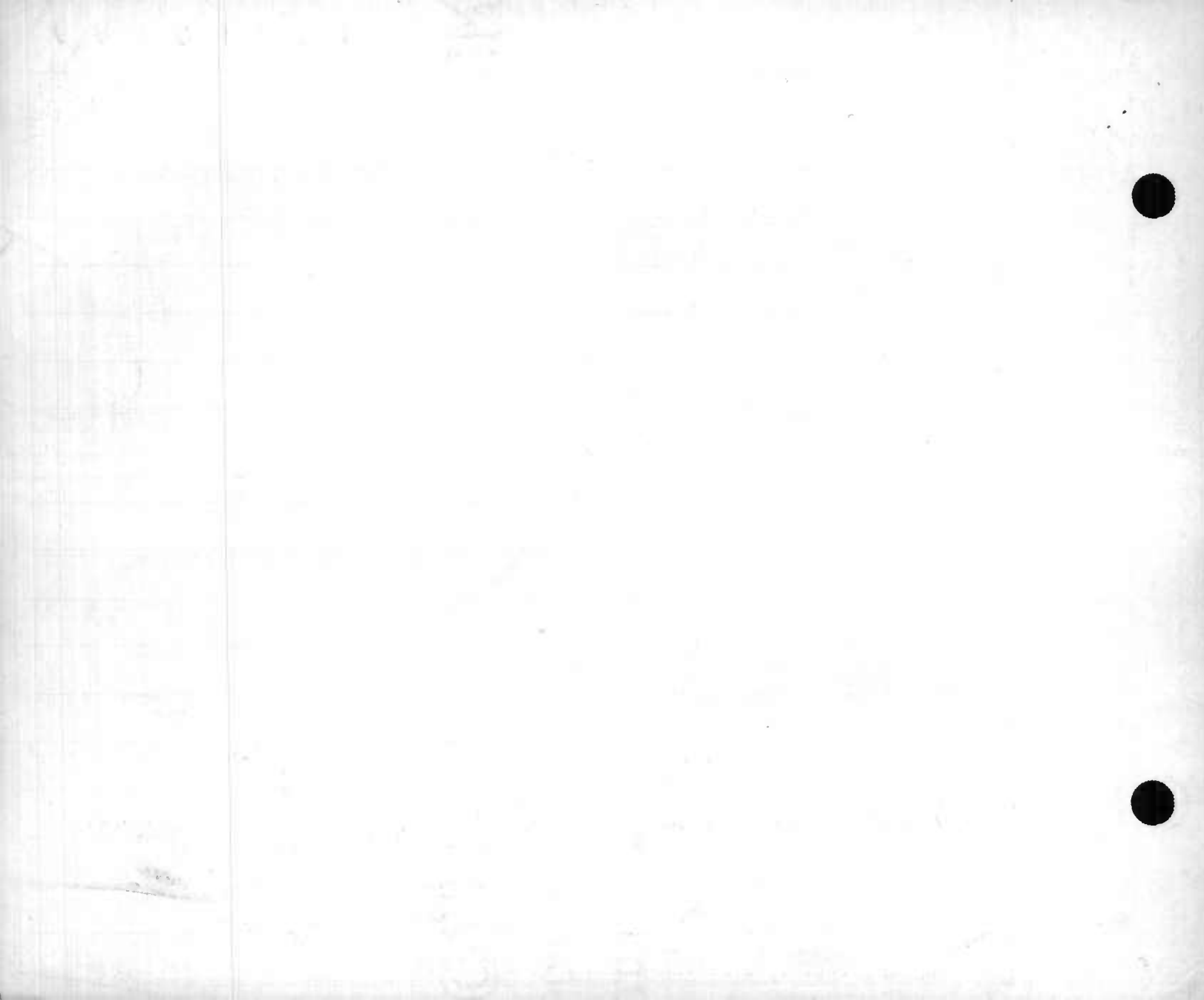
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 1 9 9	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
LOUISE DELLA CAIN						5 6 82			935 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUCASIAN		SEPT 12, 1912		69 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
SOUTH DAKOTA		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
KENSINGTON		3310 OBERON STREET				CONGRESSIONAL AIDE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3310 OBERON STREET			
MARYLAND		MONTGOMERY		KENSINGTON							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
JOSEPH RADA			ROSE SKALAR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
YES			WW II			481-07-3072			B. W. CAIN SAME AS 13 HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Widespread metastases										2 months	
1749 } DUE TO, OR AS A CONSEQUENCE OF Breast Cancer										2 1/2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9 19 80, to 5/6/ 19 82, that (I) (we) last saw the deceased alive on 5/6/ 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE						22c. DATE SIGNED					
Daniel Rosenblum MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			5/6/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Daniel Rosenblum, MD						10400 Connecticut Avenue Kensington, Md. 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			5/10/82		GATE OF HEAVEN CEM.		SILVER SPRING MONT MD.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						MAY 13 1982			Francis J. Collins		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either "1" or "2", any injury, or other traumatic event, then a medical examiner must be notified at once.

Dr. John S. Rogers notified and approved.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 2 1 3 2 0 0			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGERY JANE CAMPBELL						2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1982				2b. HOUR 7:40 P.M.			
3 SEX FEMALE		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 30 06		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 75		IF UNDER 24 HRS. HOURS MIN. 75			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School (NYC)					
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN S.S. Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3224 CORDOBA ST.					
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pinkie Fitzgerald									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 104-32-2806		17. INFORMANT ADDRESS Florence A. Campbell Same as Item # 13							
11. CAUSE OF DEATH Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR			
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE										10 YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 1976 to MAY 4 19 82 , that (I) (we) lost saw the deceased alive on APR 20 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE Lewis C. Lipson MD						DEGREE		22c. DATE SIGNED MAY 4, 1982					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS C. LIPSON						22e. ADDRESS 5530 WISCONSIN AVE, CHEVY CHASE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR MAY 7 1982		25b. REGISTRAR'S SIGNATURE James VanWarthen					

BP

Approved and returned to the office of the Director of the Bureau of the Census, Washington, D.C.

Director

Joseph W. Meade, Jr.
Special Agent in Charge
U.S. Bureau of the Census
Washington, D.C.

Approved

W. J. Meade, Jr.

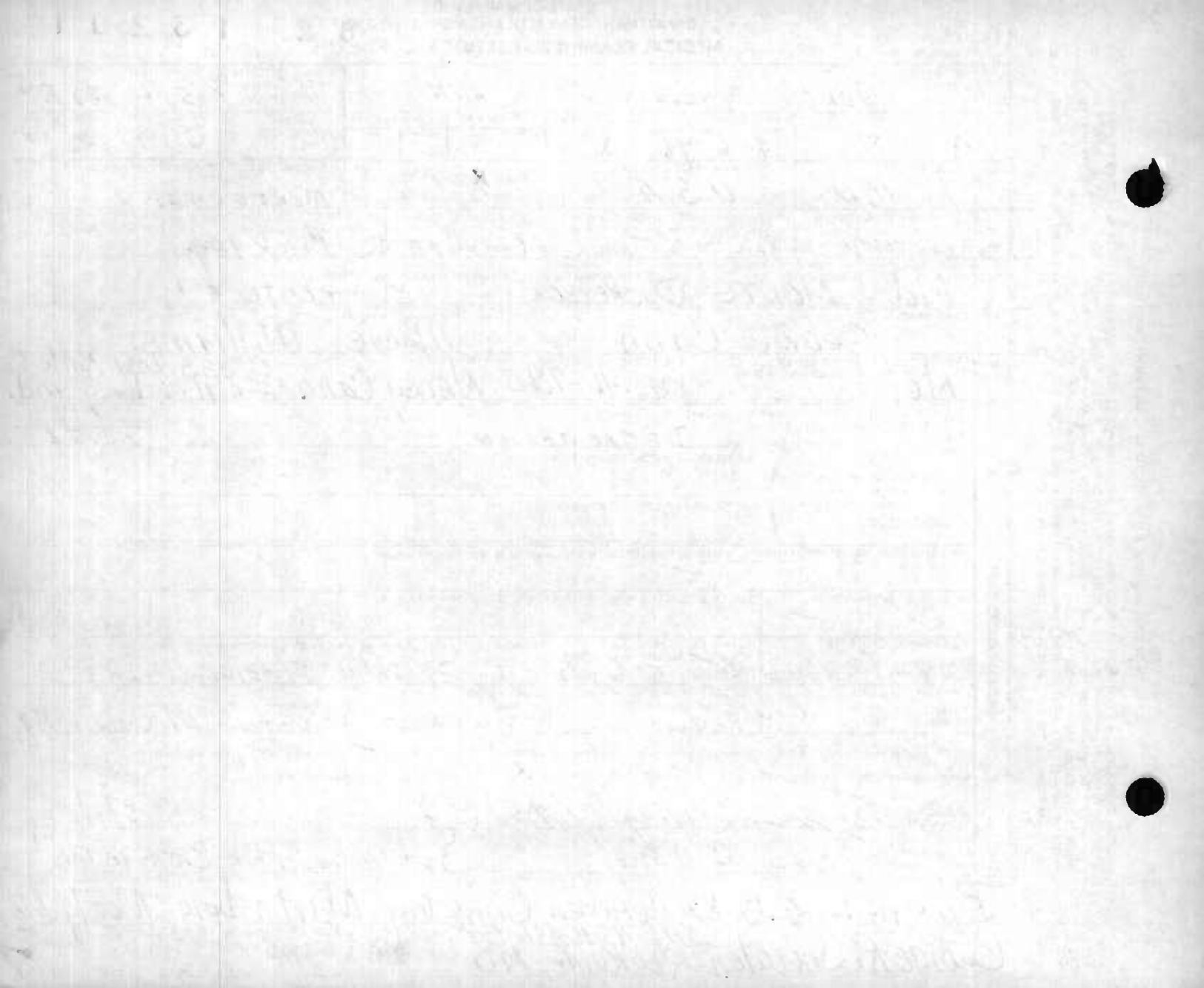
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VIR A15 ME (5))
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 2 0 1					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENE SYLVESTER CANN										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 6 19 82		2b. HOUR MIN 10 5			
3. SEX M		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 8 6 46		6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 7 19 82		2d. HOUR MIN 8 1			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH GERMANTOWN				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RAIL ROAD TRACK 24.20 mi MARKER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY MONTG				13c. CITY OR TOWN Dickerson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route # 1	
14. FATHER'S NAME FIRST MIDDLE LAST George Cann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Macie Williams				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-46-7365		17. INFORMANT ADDRESS 18 333 Lost Knife Cr. Gaithersburg Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9580 IMMEDIATE CAUSE (a) DECAPITATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10 5 P.M. 5 6 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HIT BY TRAIN FLEEING POLICE							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) RAILROAD				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 24.20 mi MARKER GERMANTOWN MONTGOMERY MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Francis C Mayle				TITLE (SPECIFY) Dpt				MEDICAL EXAMINER				DATE SIGNED 5/7/82 20814			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE				ADDRESS 8200 Wisconsin Ave Bethesda MD											
23a. BURIAL, CREMATION, REMOVAL (IF)				23b. DATE 5-12-82				23c. NAME OF CEMETERY OR CREMATORY Warren Cemetery				23d. LOCATION Martinsburg, Montg MD			
24. FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS 246 N. Wash. St Rockville, MD				25a. DATE REC'D BY REGISTRAR MAY 12 1982				25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



73 12

10. May be released to

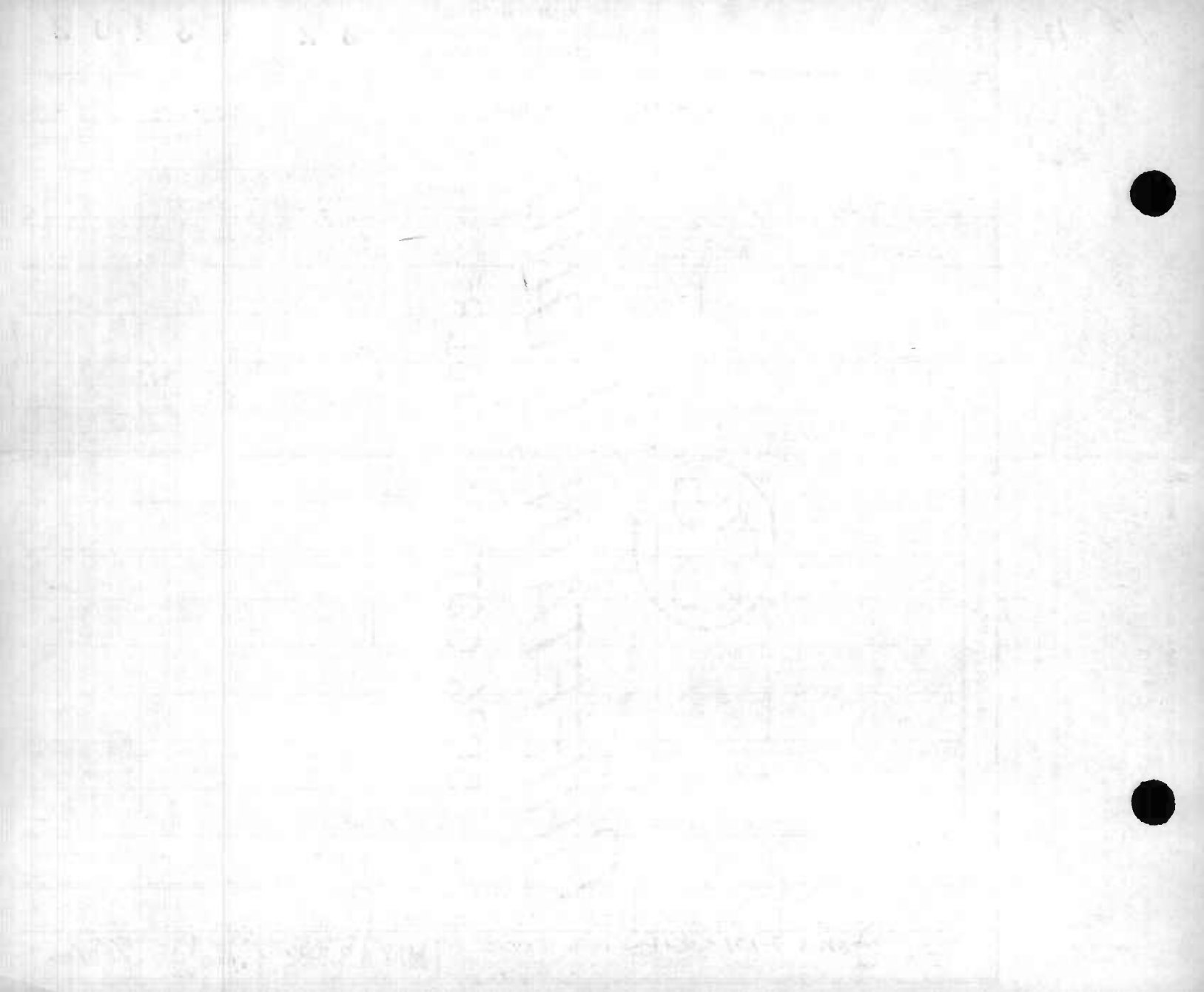
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Proper filing for the funeral director should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 2 1 3 2 0 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) W. Beverly Carter					2a. DATE OF DEATH MONTH DAY YEAR 5-09 -82			2b. HOUR 3 A M	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diplomat		12b. KIND OF BUSINESS OR INDUSTRY State Depart.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY Wash., DC		13b. CITY OR TOWN Wash., DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1201 Juniper Street, N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST Dr. William B. Carter					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Green				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 189-16-0647		17. INFORMANT ADDRESS William B. Carter III 1201 Juniper St., NW Washington, DC 20012					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 76 , 19 82 , to 19 82 , that (I) (we) last saw the deceased alive on 5-8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Francis J. Finnerly DEGREE					22c. DATE SIGNED 5-9-82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK A. FINNERTY D	
22e. ADDRESS 916 19th St NW Wash									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/10/82		23c. NAME OF CEMETERY OR CREMATORY Lee & Son's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME John F. Baldwin ADDRESS 7400 Georgia Ave Wash., DC 20012					25. DATE REC'D. BY REGISTRAR MAY 13 1982 REGISTRAR'S SIGNATURE Frances Jean Parthen				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 2 1 3 2 0 3			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Luna Brown Cason						2a. DATE OF DEATH MONTH DAY YEAR May 5, 1982				2b. HOUR 4:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence - 2212 Hermitage Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Arkansas		13b. COUNTY Ashley		13c. CITY OR TOWN Fountain Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS RFD - Fountain Hill				14. FATHER'S NAME FIRST MIDDLE LAST Samuel Abraham Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annis ? Cobb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-50-0940		17. INFORMANT Marie Eackles - Harpers Ferry, W V 25425		P. O. Box 35							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 Arteriosclerotic Heart Disease IMMEDIATE CAUSE (a) Sudden Death DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bilateral Pulmonary Fibrosis + Chronic Bronchitis + Rheumatoid Arthritis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 28 April 1982 to 5 May 1982 , that (I) (we) lost saw the deceased alive on 30 April 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.													
22b. SIGNATURE Russell B. Arnold M.D.				DEGREE M.D.				22c. DATE SIGNED 5/5/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell B. Arnold M.D.				22e. ADDRESS 1106 Spring Street, Silver Spring, Md. 20910									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/82		23c. NAME OF CEMETERY OR CREMATORY Flat Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fountain Hill, Ashley, Ark.							
24. FUNERAL DIRECTOR NAME Robert L. Spencer		ADDRESS P. O. Box C Harpers Ferry, WV		25. DATE REC'D. BY REGISTRAR MAY 13 1982		REGISTRAR'S SIGNATURE James VanNathan							

BP

10/10/77

Female	White	Oct. 20, 1978	63	1000	1000
Adolescent	USA				
Black Spring	Black Spring - 5112	1000	1000	1000	1000
Adolescent	Adolescent	5112	1000	1000	1000
Adolescent	Adolescent	1000	1000	1000	1000
Adolescent	Adolescent	1000	1000	1000	1000

10/10/77

Black Spring - 5112

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13204	
1. DECEASED NAME (TYPE OR PRINT) John M. Castell						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5/28 1982		2b. HOUR AM PM 1:00 P.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1905	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 76 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/28 1982	2d. HOUR AM PM 1:00 P.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D C		7b. CITIZEN OF WHAT COUNTRY? U S America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2404 Seibel Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Accounting				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2404 Seibel Drive			
14. FATHER'S NAME FIRST MIDDLE LAST John M Castell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Frech							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Navy WWII		17. INFORMANT ADDRESS Florence J. Castell (same as #13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Silver Spring		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Silver Spring, Montgomery, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy				DATE SIGNED 5/28/82					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-82		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Blandensburg Maryland					
24. FUNERAL DIRECTOR Warner E. Humphrey		8434 Ga. Ave. ADDRESS Sil. Spr. Md.		25a. DATE OF BY REGISTRATION JUN 4 1982		25b. REGISTRAR SIGNATURE <i>James J. Smith</i>					

1000



SECTION

23, 30

Handwritten notes and markings at the bottom left corner, including what appears to be a signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 276-6969.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR		8 2 1 3 2 0 5							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JARED MICHAEL CHAFFIN				2a. DATE OF DEATH MONTH DAY YEAR 05 17 82		2b. HOUR 7:14 a.m.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 05 14 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 0 3		7. UNDER 24 HRS. HOURS MIN. 0 3	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BERMUDA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN See 17.					
14. FATHER'S NAME FIRST MIDDLE LAST RONALD CHAFFIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHERYLE ANNE MORRIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS RONALD CHAFFIN, NAS BERMUDA, P.O. BOX 456, FPO New York, NY 09560			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoplastic Left Heart 7468 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 17 May 1982, to 17 May 1982, that (I) (we) lost saw the deceased alive on 17 May 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Louden Nalle				DEGREE		22c. DATE SIGNED 17 MAY 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUDEN NALLE, LTCOL, USA				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-1982		23c. NAME OF CEMETERY OR CREMATORY Willamette National		23d. LOCATION CITY OR TOWN COUNTY STATE Portland, Multnomah, Or.			
24. FUNERAL DIRECTOR W. W. Chambers Co 8655 Georgia Ave, S. S, MD				25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

0018

Page 1 of 1
Date: 10/10/1971
Time: 10:10

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

10/10/1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 2 1 3 2 0 6					
1 - FOR STATE REGISTRAR					REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) WILLIAM A. CHAPMAN, SR.					2a. DATE OF DEATH MONTH MAY DAY 1 YEAR 1982					2b. HOUR 8:15 PM					
3. SEX Male		4. RACE white		5. DATE OF BIRTH SEPT. 9 03 98		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS				7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS. HOURS 0 MIN. 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY Housing					
13a. STATE Maryland					13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 217 Water st.				
14. FATHER'S NAME FIRST Clarence MIDDLE Albert LAST Chapman					15. MOTHER'S MAIDEN NAME FIRST Lilly MIDDLE Agnes LAST Kelly										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 578-14-5297		17. INFORMANT Richard Chapman, Sr.					ADDRESS Washington Grove Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar pneumonia 5860 DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) year										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic renal brain syndrome															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from March 24 19 81 , to May 1 19 82 , that (I) (we) lost saw the deceased live on 5/1 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did and not) view the body after death.															
22b. SIGNATURE Martin C. Shargel					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5/2/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL M.D.					22e. ADDRESS 3720 FARRAGUT Ave KENSINGTON MD-20895										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION					23b. DATE MAY 2, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory				23d. LOCATION CITY OR TOWN Washington, D. C. COUNTY STATE				
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER ADDRESS LAYTONSVILLE, MD. 20879										25a. DATE REC'D. BY REGISTRAR MAY 6 1982				25b. REC'D. BY [Signature]	

BP

250

10

• Electron spin: An intrinsic angular momentum of electrons, which gives rise to its magnetic moment.

DHMH - T7
(VR A15 ME (5))
15M2/80

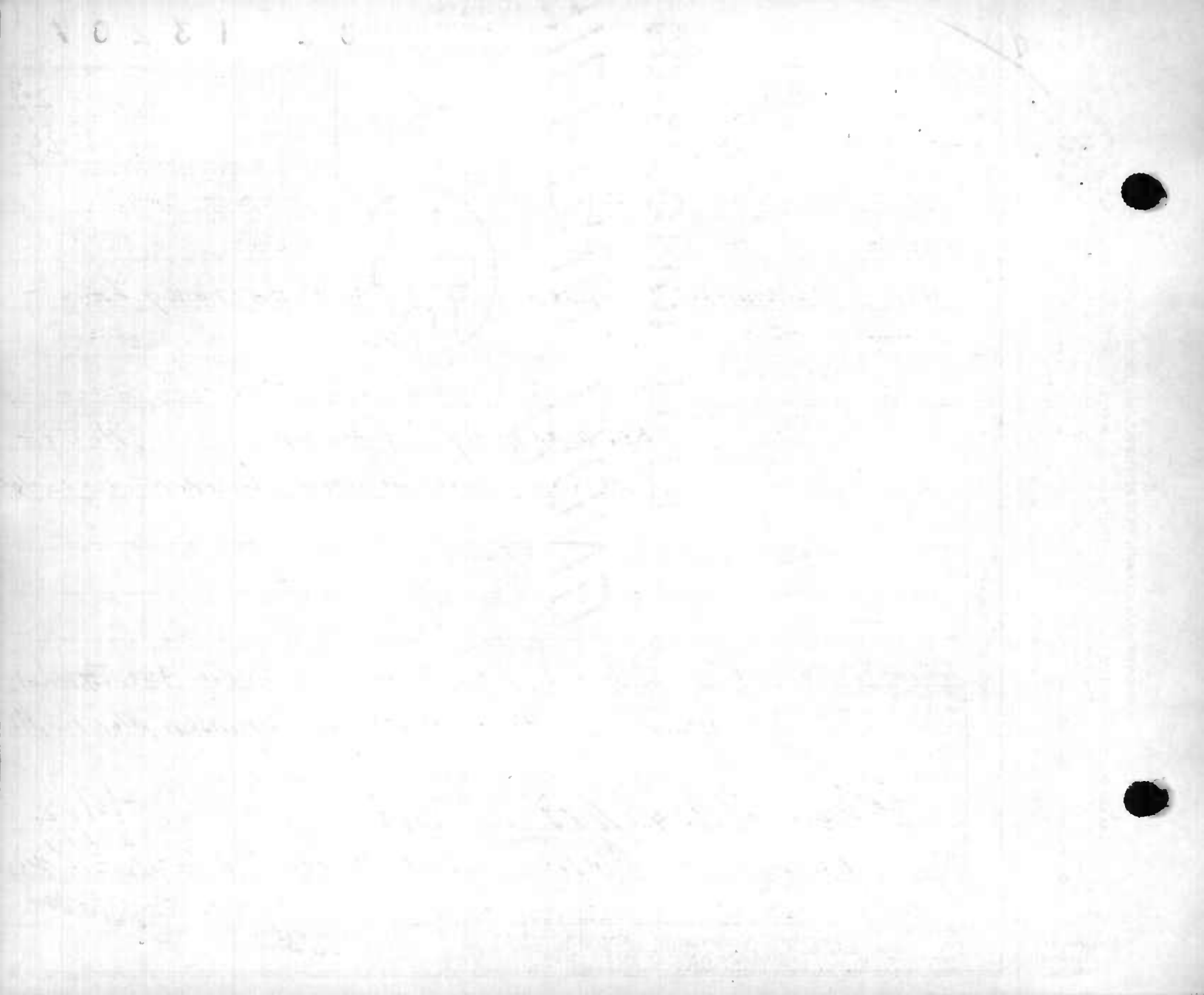
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 2 0 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Hilda M. Chartier								20. DATE KNOWN OF DEATH		5/6/82		20		20		20					
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
female		cauc		5/30/17		64 YRS.		MONTHS		DAYS		HOURS		MIN.		5/6/82		20		20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
New Hampshire				United States				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Montgomery County									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda				Suburban Hospital				Homemaker				Home									
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
MD				Montgomery				BETHESDA				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				4977 BATTERY LANE					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
Harvey Paul Marsh				Florence Leavitt																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
No				003 18 1419				Husband				Armand P. Chartier Same as item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																ACUTE					
5-188 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE																10-12 YR.					
DUE TO, OR AS A CONSEQUENCE OF																					
(b) CHRONIC PULMONARY DISEASE																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
				1 P.M. 5/6/82				Laid Down on Couch and Expired													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
				Home				4977 BATTERY LANE BETHESDA MONT MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED									
Francis C. Mayle				Dyst								5/6/82									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Francis C. Mayle				8200 Wisconsin Ave Bethesda MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				May 12, 1982				Arlington National				Arlington Virginia									
24. FUNERAL DIRECTOR																25a. DATE REC'D. BY REGIONAL		25b. REGISTRAR'S SIGNATURE			
NAME ROBERT A. DUMPHREY FUNERAL HOMES, P. A., BETHESDA, MARYLAND																MAY 12 1982		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	3	2	0	8			
1- FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MAYE W. CHASE										2a. DATE OF DEATH MONTH DAY YEAR 5 12 82 2b. HOUR 7:45 P.M.									
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 4 14 1907			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Stationary Store				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Prince George's			13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7401 New Hampshire Ave. #615							
14. FATHER'S NAME FIRST MIDDLE LAST James Caldwell Walker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Brannen Rollins					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---					16b. SOCIAL SECURITY NO. 043-28-5464				
17. INFORMANT ADDRESS 112 Alder Avenue Samuel C. Ford Wayne, New Jersey																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Genl atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u> <u>Years</u> <u>Years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>april</u> , 19 <u>80</u> , to <u>5-12</u> , 19 <u>82</u> , that (I) <u>may</u> lost saw the deceased alive on <u>5-12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did) view the body after death.																			
22b. SIGNATURE DEGREE <u>Jack Schumacher M.D.</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-12-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M. D.										22e. ADDRESS 105 Russell Ave, Gaithersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland									
24. FUNERAL DIRECTOR NAME Howard E. Hale, P. O. Box 7428 Warner E. Pumphrey, Inc., Sil. Spr., Md.																			
25a. DATE REC'D. BY REGISTRAR MAY 17 1982										25b. REGISTRAR'S SIGNATURE <u>Kim J. Miller</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 1 3 2 0 9				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) VICTORIA CHATMAN					2a. DATE OF DEATH MONTH DAY YEAR 5 19 82			2b. HOUR 2 05 P.M.	
3. SEX Female		4. RACE Balck		5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.			
10. CITY OR TOWN OF DEATH Washington, D.C.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Sorter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Washington, D.C.			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1529 41st Street, S.E.		
14. FATHER'S NAME FIRST MIDDLE LAST John White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 579 54 3313		17. INFORMANT ADDRESS S.E., Washington, D.C. Gary Chatman-husband-1529 41st Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER STAGE III 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Luis A. Heffess MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A. HEFFESS					22e. ADDRESS 9811 MALLARD DRIVE LAUREL, MD				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE May 22 1982		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY Suitland, Md.		
24. FUNERAL DIRECTOR NAME John F. Stewart					24b. REC'D. BY REGISTRAR 1982		24c. REGISTRAR'S SIGNATURE		
25. FUNERAL HOME Stewart Funeral Home-4001 Benning Rd. N.E.									

BP

8 2 1 3 2 0 9

1950-1951

USA

Washington, D.C.

1950-1951

1950-1951

1950-1951

100% Cotton

1950-1951

1950-1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 1 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Solomon N. Chesivoir</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>5/8/82</u>			2b. HOUR <u>10:20 P</u>
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>1 15 04</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>P.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carriage Hill N.H.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Restaurant</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
13a. STATE <u>Md.</u>				13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Silver Spring</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JAMUEL CHESIVOIR</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>JENNIE GOLDSTEIN</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>577-38-2547A</u>		17. INFORMANT ADDRESS <u>5509 Md. Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> 19 <u>82</u> 3/20 to <u>5/8</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Penney Bisk</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/9/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PENNEY BISK MD</u>				22e. ADDRESS <u>8630 FENTON ST SILVER SP. Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-11-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ohev Sholom Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR NAME <u>Danzansky-Goldberg Chapels; 1170 Rockville Pike</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 12 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

The first of these is the
 fact that the system is
 not self-sufficient. It
 requires a constant supply
 of raw materials and
 energy. This is a major
 problem for the system
 as a whole. The second
 problem is the fact that
 the system is not
 flexible. It is unable to
 adapt to changing
 conditions. This is a
 major problem for the
 system as a whole. The
 third problem is the fact
 that the system is not
 efficient. It wastes a
 great deal of energy and
 resources. This is a
 major problem for the
 system as a whole.

The fourth problem is the
 fact that the system is
 not secure. It is vulnerable
 to attack from both
 inside and outside. This
 is a major problem for
 the system as a whole. The
 fifth problem is the fact
 that the system is not
 sustainable. It cannot
 continue indefinitely. This
 is a major problem for
 the system as a whole.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 2 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (THREE PRINTS) Thomas Burch Clark				2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982		2b. HOUR P M 12:55 P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) North American Van Lines		12b. KIND OF BUSINESS OR INDUSTRY Sales	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Regan		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None			
16b. SOCIAL SECURITY NO. 577-09-2802		17. INFORMANT ADDRESS Mrs. Elizabeth Clark (wife) same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 2000 } DUE TO, OR AS A CONSEQUENCE OF (b) Gram Negative Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Diffuse Histiocytic lymphoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1982, to May 9, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 9, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE James H. Shelhamer MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Shelhamer				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Washington, D.C.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James H. Shelhamer	

1 3 1 1

1941

March

1941

March



11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11



11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

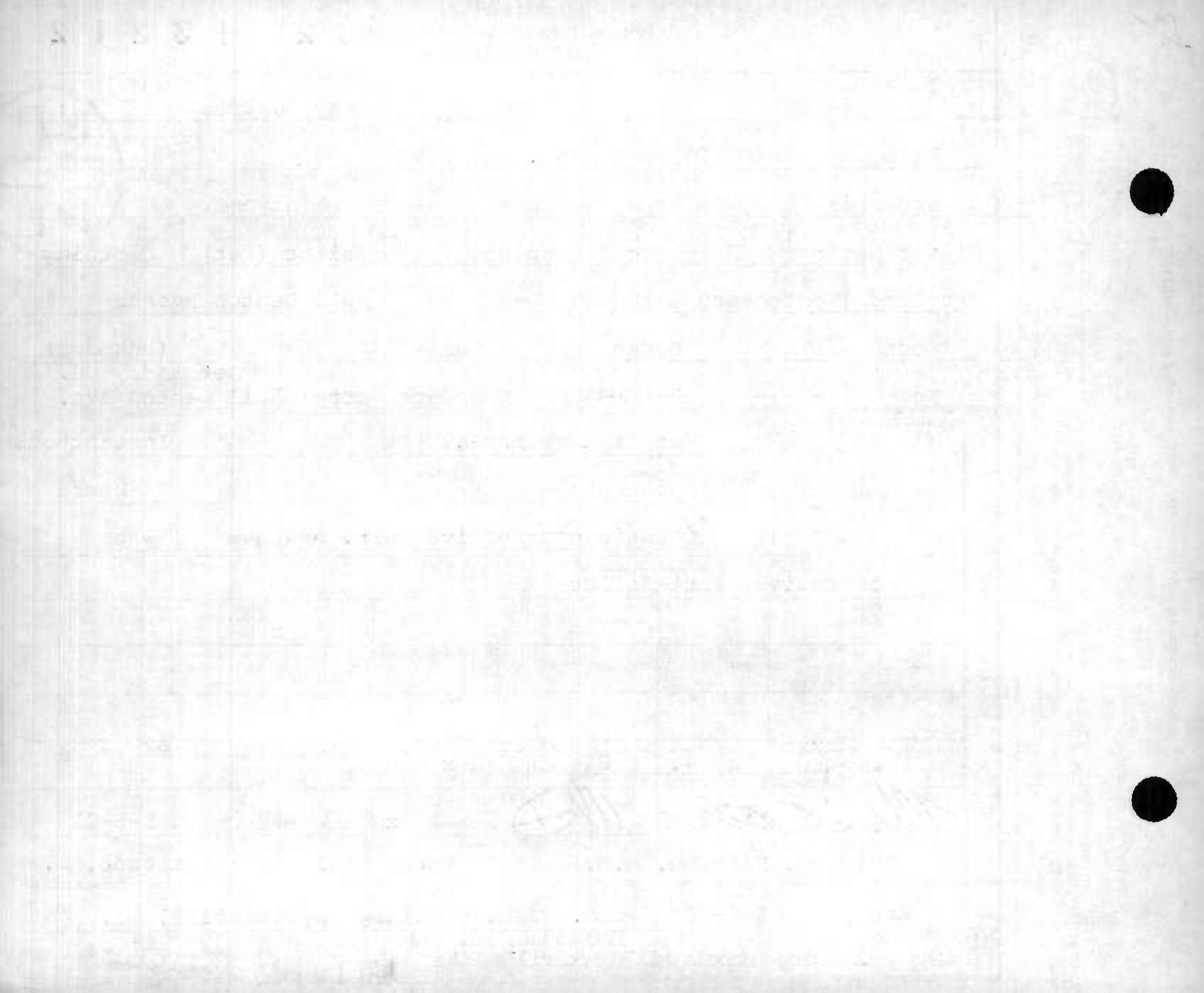
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) SAMUEL COHEN					2a. DATE OF DEATH MONTH DAY YEAR May 5, 1982		2b. HOUR 12:29 pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 85		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roumania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5011 Benton Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Leon Cohen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578-48-9420		17. INFORMANT ADDRESS Bethesda, Md. Theodora Perry; 5011 Benton Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instantaneous
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									72 hours
(b) DUE TO, OR AS A CONSEQUENCE OF Pneumonia									Years
(c) DUE TO, OR AS A CONSEQUENCE OF Chronic obstructive pulm. disease									Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive heart failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from October 63 to May 5, 1982 , that (I) (<input checked="" type="checkbox"/>) lost saw the deceased alive on May 4, 1982 , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above. (If yes, did you examine the body after death.)									
22b. SIGNATURE <i>Morton W. Shapiro, M.D.</i>						22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5-5-82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MORTON W. SHAPIRO, M.D.				22f. ADDRESS 5225 Pooks Hill Road; Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-6-82		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Md.			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
Earl (NMV) Cole		MAY 23 82		23		82		8122		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. IF UNDER 24 HRS		10. IF UNDER 24 HRS	
Male	Cau.	AUGUST 14, 1920	61	YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA	USA		MONTGOMERY MD.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY								
Rockville	Shady Grove Adventist	DRYWALL Labor	Construction								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS?	13f. STREET ADDRESS						
Md	Montgomery	Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	17600 Sequoia Ave						
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES - NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)									
HERBERT COLE	NORA TOMBILSON	227-262451									
17. INFORMANT ADDRESS		WANDA COLE SAME AS # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Anoxic encephalopathy.											
DUE TO, OR AS A CONSEQUENCE OF (b) Massive gastrointestinal hemorrhage.											
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary edema.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Aspiration pneumonia, Renal failure											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
	P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5/23/82 19, to 5/23/82 19, that (I) (we) last saw the deceased alive on 5/23/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE	DEGREE	22c. DATE SIGNED									
Susan J. Withrow	ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	May 24, 1982									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS										
SUSAN J. WITHROW	GAITHERSBURG, MD. 20877										
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION								
BURIAL	May 26, 1982	LAYTONSVILLE	LAYTONSVILLE MONT. MD.								
24. FUNERAL DIRECTOR	25. DATE RECD. BY REGISTRAR	25. REGISTRAR'S SIGNATURE									
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879	MAY 27 1982										

BP

1287 28

1287 28



1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28

1287 28



20+1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13214			
1. DECEASED NAME (TYPE OR PRINT) Elmer F. CLOW JR										2a. DATE KNOWN OF DEATH MAY 31 1982		2b. DATE OF DEATH MAY 31 1982			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Dec 6 27 54		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 54		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 0 0 0 0		7. IF UNDER 24 HRS. HOURS MIN 0 0		2c. DATE PRONOUNCED DEAD MAY 31 1982			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Sil. Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hily Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRIMINAL INVESTIGATOR				12b. KIND OF BUSINESS OR INDUSTRY IRS			
13a. STATE MD				13b. COUNTY Mont				13c. CITY OR TOWN Sil. Spg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4510 Lovejoy St.	
14. FATHER'S NAME FIRST MIDDLE LAST ELMER E. CLOW SR.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCILLE A. WALDRON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1952				17. INFORMANT LUPE CLOW				17. ADDRESS SAME AS 13		17. WIFE WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None															
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? (YES) <input checked="" type="checkbox"/> (NO) <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) MD. Dep.				MEDICAL EXAMINER				DATE SIGNED MAY 31 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/4/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE James J. Collins							
500 UNIV. BLVD. W., SILVER SPRING, MARYLAND 20901															

X

Covering physician for Dr. Kelly.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please reinsert carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Duffy Connors			2a. DATE OF DEATH MONTH 05 DAY 22 YEAR 82			2b. HOUR 4 MIN 25				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 05 YEAR 63		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chew Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing/Retirement				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dir. Education		12b. KIND OF BUSINESS OR INDUSTRY AFL-CIO		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chew Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8602 Woodbrook Ln.		
14. FATHER'S NAME FIRST Thomas F. MIDDLE Connors LAST Connors				15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 023-12-6953		17. INFORMANT ADDRESS 8602 Woodbrook Ln. Chew Chase, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (c) 3 day.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Alzheimer's disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 5/22/82 to 5/22/82 , that (we) lost saw the deceased alive on 5/22/82 and that in (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE Jane Duggan MD						22c. DATE SIGNED 5/22/82		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)						22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 5-23-82			23c. NAME OF CEMETERY OR CREMATORY Georgetown Med. School			23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service, Alexandria, Va. ADDRESS						25a. REG'D. BY REGISTRAR JUN 1 1982				

13-11-11

11-11-11

11-11-11

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16-50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 2 1 6

1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise A. Corbin			2a. DATE OF DEATH MONTH DAY YEAR 5-1-82			2b. HOUR 5³⁵ PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-05-06		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.			13b. COUNTY MONT		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST E. FERDM NICHOLSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA CORBIN			13e. STREET ADDRESS 9117 GLEN RIDGE RD.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 21A		17. INFORMANT Daughter ADDRESS FRANCES ACCORDINO - SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for <u>immediate</u> and <u>underlying</u> causes.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardipulmonary arrest 4151 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 1 day										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I (this hospital) attended the deceased from 5-1-82 19 82 , to 5-1-82 19 82 , that (we) last saw the deceased alive on 5-1-82 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.												
22b. SIGNATURE Morris Perry			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-1-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS PERRY			22e. ADDRESS M.D. 11602 Georgia Ave. S.S. Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-4-82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE SWITLAND, P. G. MD				
24. FUNERAL DIRECTOR J. Ch...			24b. FUNERAL HOME DEVOL FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR MAY 6 1982			25b. REGISTRAR'S SIGNATURE James G. ...			

Received at 11:00 AM 2013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Emilio ERNESTO Coscarelli</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>MAY 5 1982</i>			2b. HOUR <i>1:02 AM</i>					
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Mary's Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SHOE MAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SELF EMPLOYED</i>			
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>WHEATON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3802 KELSEY STREET 20906</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>DIEGO COSCARELLI</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ROSARIA MICELI</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>084-10-0819</i>		17. INFORMANT <i>ELZA M. LEOTTA</i>			ADDRESS <i>SAME AS 13</i>		DAUGHTER	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Bronchitis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4RS</i> <i>4RS</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/4</i> 19 <i>82</i> to <i>5/5</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>8/4</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R.T. Benack MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/5/82</i>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.T. Benack MD</i>						22e. ADDRESS <i>4115 Colie DR. Wheaton MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>5/15/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS</i> <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAY 17 1982</i> <i>Anna J. [Signature]</i>					

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

13511

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 2 1 3 2 1 8**
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth L. Costantinou			2a. DATE OF DEATH MONTH DAY YEAR 5/31/82 5/31/82		2b. HOUR 2:45 P.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-1-12	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9705 FAIRWAY AVENUE
14. FATHER'S NAME FIRST MIDDLE LAST Archibald Lindsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maretta Pilling			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 578 01 0592		17. INFORMANT ADDRESS Same as above Costos Costantinou (Husband)	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypoxemia, hypoxypnea + respiratory acidosis</u>	Months
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u>	Years
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>5/24</u> , 19 <u>82</u> , to <u>5/31</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN		22c. DATE SIGNED 5-31-82	
22d. ADDRESS 9741 COLUMBIA BLVD SILVER SPRING MARYLAND 20910		22e. MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/2/82	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUN 3 1982	

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 1 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Josephine A CRAPANZANO				2a. DATE OF DEATH MONTH DAY YEAR 5-16-82			
3. SEX Female				4. RACE Cauc.			
5. DATE OF BIRTH MONTH DAY YEAR MAY 5 13 02				6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker				12b. KIND OF BUSINESS OR INDUSTRY —			
13a. STATE MD				13b. COUNTY Montgomery			
13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 14020 Astaway Drive				14. FATHER'S NAME FIRST MIDDLE LAST JAMES - QUIRK			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES - GLEASON				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 042-48-5275				17. INFORMANT ADDRESS Marcia-Jo Landers Same as # 13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 1569 IMMEDIATE CAUSE (a) Carcinoma biliary tract DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 4-28-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED same as 18. a.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-15 19 82 , to 5-16 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 5-15 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE G. Sengstack M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-16-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Sengstack M.D.				22e. ADDRESS Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAY 15 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

1 2 2 1 9

Handwritten notes and signatures on lined paper, including the date 11-22-82 and the name "B. J. [unclear]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8 2 1 3 2 2 0	
1. DECEASED NAME (TYPE OR PRINT) FRANK P. CRAWFORD		2a. DATE OF DEATH MAY 13 1982		2b. HOUR 6:30 P.M.	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH FEB 24, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. CHIEF CLERK		12b. KIND OF BUSINESS OR INDUSTRY SO. RAILWAY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME GEORGE CRAWFORD		15. MOTHER'S MAIDEN NAME UNKNOWN MARCERON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 718-10-5700		17. INFORMANT NEPHEW J. F. OREM	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 2639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE ABCESES & CELLULITIS (c) SENILE INANITION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH 3 MONTHS 1 YEAR			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBROVASCULAR INSUFFICIENCY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 15 1981 to MAY 13 1982, that (I) (we) last saw the deceased alive on MAY 5 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Martin C. Shargel		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL		22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD - 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		23e. DATE REC'D. BY REGISTRAR MAY 17 1982			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25. REGISTRAR'S SIGNATURE Francis J. Collins			

0 2 1 3 2 0

one more

1972-1973

1972-1973 - 1973-1974

1974

1974-1975

1975-1976

1976-1977

1977-1978

1978-1979

1979

1980-1981

1981-1982

1982-1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13221	
1. DECEASED NAME (TYPE OR PRINT) John JOSEPH Crotty JR										2a. DATE KNOWN OF DEATH ESTIMATED May 11 1982	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Feb 12 31 51		6. AGE IN YEARS (LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD May 11 1982		2b. HOUR 8:00 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL DOCTOR		12b. KIND OF BUSINESS OR INDUSTRY F.D.A.			
13a. STATE MD		13b. COUNTY Monts		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3516 John Carroll Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. CROTTY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL M. DONNELLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1961-1963		17. INFORMANT MARCELLA K. CROTTY		ADDRESS SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Dep M.D.				MEDICAL EXAMINER May 11, 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

1 2 3 4 5 6 7 8 9 10 11 12

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101

102

103

104

105

106

107

108

109 110

111

Item 10 g568 6/7/82 g3

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 2 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CROWN, JOSEPH				2a. DATE OF DEATH MONTH DAY YEAR 5/17/82				2b. HOUR 9:50 AM			
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 1 5 1919		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD					
10. CITY OR TOWN OF DEATH Wheaton, Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY MONTG		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2601 BEL PRE RD.			
14. FATHER'S NAME FIRST MIDDLE LAST John CROWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-48-242		17. INFORMANT JAMES F. COTTON		ADDRESS WASH. DC 2700 M.L.K. AVE. S.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Consecutive Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (4140) (c) Arteriosclerotic Heart Disease (4140) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/10 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/17 19 82 to 5/17 19 82 that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. T. BENACK MD				DEGREE MD				22c. DATES SIGNED 5/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. BENACK MD				22e. ADDRESS 4115 Blie DR. Wheaton MD							
23a. BURIAL, CREMATION, REMOVAL CREMATION				23b. DATE 5-18-82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE Wheaton MD			
24. FUNERAL DIRECTOR NAME JOHNSON & JENKINS										ADDRESS 714 KENNEDY ST NW	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Paper to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MDHM - 16 50M 1/81
(VRA 15, 4)

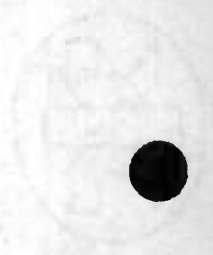
DATE RECD BY REGISTRAR: MAY 27 1982

2 2 2 2 1 2 2 2

6

2/1/2

1920-1921



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 2 2 3
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} Ruth ^{MIDDLE} Deakins ^{LAST} CZESKLEBA		2a. DATE OF DEATH MONTH DAY YEAR 5 31 82	
3 SEX FEMALE		2b. HOUR 10:08 PM	
4 RACE WHITE		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
5. DATE OF BIRTH MONTH DAY YEAR 1 29 05		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Assist.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARE SLYVAN MANOR HEALTH CENTER		12b. KIND OF BUSINESS OR INDUSTRY U.S. G.O.V.	
13a. STATE MD.		13b. STREET ADDRESS 10306 GLOBE DR.	
13c. COUNTY HOWARD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. CITY OR TOWN ELLICOTT CITY		13f. STREET ADDRESS	
14. FATHER'S NAME ^{FIRST} JAMES ^{MIDDLE} ^{LAST} DEAKINS		15. MOTHER'S MAIDEN NAME ^{FIRST} Mary ^{MIDDLE} Ellen ^{LAST} unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.	
17. INFORMANT Irwin V. Czeskleba, Item 13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. SIGNATURE B.N. ROSENBAUM, M.D.		22b. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895	
22c. DATE SIGNED 5/31/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSENBAUM, M.D.	
22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895		22f. DATE SIGNED 5/31/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1982	
23c. NAME OF CEMETERY OR CREMATORY Howard Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Long Corner, Howard, Md.	
24. FUNERAL DIRECTOR NAME Glen L. Molesworth, P.A., Damascus, Md.		25a. DATE OF DEATH BY REGISTRAR 5/31/82	

1358

1358

1358

1358

1358

1358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 2 1 3 2 2 4 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Roger Lee Dade, JR.					MONTH DAY YEAR HOUR 05 10 82 10 ¹⁵ A M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		CAUCASIAN		MONTH DAY YEAR MAY 23, 1913		68 YRS.		10 ¹⁵ A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOURS	
MARYLAND		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		SUPERVISOR		U.S. GOVT.			
13a. STATE					13b. INSIDE CITY LIMITS?				
MARYLAND					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST ROGER LEE DADE, SR.					FIRST MIDDLE LAST SUSAN BALL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
YES					WW II 579-05-8934				
17. INFORMANT					ADDRESS				
EVELYN C. SHAUGHNESSY					SAME AS 13 FIANCEE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pul. arrest</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebrovascular accident.</i> (c) <i>atherosclerosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Diabetes mellitus</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>5-9-82</i> to <i>5-10-82</i> , that (2) (we) lost <i>5-10-82</i> above (3) (we) (did) (did not) view the body after death, and that (4) (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE					22c. DATE SIGNED				
<i>John L Ford</i>					<i>5/10/82</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
JOHN L FORD					344 University Blvd W Silver Spring Md 20901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
ENBOMBMENT			5/13/82		GATE OF HEAVEN MAUSOLEUM			SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
FRANCIS J. COLLINS					MAY 17 1982				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					REGISTRAR'S SIGNATURE				
					<i>Thomas J. ...</i>				

Shelby, Alabama.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 2 2 5			
1. DECEASED NAME (TYPE OR PRINT) PAUL J. DADEY				2a. DATE OF DEATH MONTH DAY YEAR 5 20 82			
3. SEX Male				2b. HOUR 8 55 M			
4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 18 30 59		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Spr.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Dadey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernadine Skopek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-74-4984			
17. INFORMANT Joseph Dadey-father-				ADDRESS (same as 13e) 1027 Tracy Drive,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple myeloma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUG. 1 , 19 79 , to MAY 20 , 19 82 , that (I) (we) lost saw the deceased alive on MAY 20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hubert J. Alpert DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 20, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert J. Alpert, MD				22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.	
24. FUNERAL DIRECTOR Hines, Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Theresa J. Kishner	
11800 N.H. Ave., S.S. Md							

BP

1203 11 1912

1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) DAVID M. DANTZIC			2a. DATE OF DEATH Month MAY Day 29 Year 1982		2b. HOUR 6:15 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12/5/1913		6. AGE (In years lost birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 15306 Barningham Ct.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Optometrist		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15306 Barningham Ct.
14. FATHER'S NAME First Middle Last Samuel J. Dantzic		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-20-0928	17. INFORMANT 15306 Barningham Ct. Address Villa R. Dantzic Sil. Spr., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1991 (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITIS ; ABDOMINAL AORTIC ANEURYSM					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1966 , to May 29, 1982 , that (I) (we) last saw the deceased alive on May 25, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold W. Draper, M.D.		22c. DATE SIGNED May 29, 1982	22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.		
22e. ADDRESS 9801 GEORGIA AVE, SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 5/31/82	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	23d. LOCATION (City or Town) (County) (State) DATE JUN. 4 1982		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Sil. Spr., Md.		25a. REGD. BY REGISTRAR Charles Santhos	25b. REGISTRAR'S SIGNATURE Charles Santhos		

THE UNIVERSITY OF MICHIGAN

LIBRARY

1913

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

THE UNIVERSITY OF MICHIGAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 2 7			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Willard C. Daves				MONTH DAY YEAR 5/29/82			
3. SEX female				2b. HOUR 12:02 M			
4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6/24/1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Knoxville, Tenn.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Bethesda			
13c. COUNTY Montgomery				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Cansler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian - Webber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 414-92-2376			
17. INFORMANT ADDRESS Carolyn L. Reinhardt (Daughter) Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7991 IMMEDIATE CAUSE (a) Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Danea C. Sadin MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JF 3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Danea C. Sadin				22e. ADDRESS 2141 K St NW, Washington DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 31, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR J. William Lee's Sons Co. 300-4th St., NE, Wash., DC				25a. DATE REC'D. BY REGISTRAR JUN 1 1982			

Knowlton, Tenn. United States

Honorable

Montgomery, Alabama

Charles

11-2-2370

Washington, D.C.

11-2-2370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR					8 2 1 3 2 2 8					
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
HELEN Rose DAVIS					May 18 1982 8:55 am					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
female		white		11 29 20		61		8:55 am		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
New Jersey		USA				Montgomery MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		4419 Independence Street				Secretary		C & W Assoc.		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Maryland					Montgomery		Rockville		4419 Independence Street	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Ellswort F. Marble					Helen A. Cox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes					WW II		142-14-6520 Rebecca A Davis same as 13c			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									3 MONTHS	
IMMEDIATE CAUSE (a) SMALL CELL CANCER OF LUNG										
1629 DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 82 to MAY 17 19 82, that (I) (we) lost the deceased on MAY 7 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Daniel Rosentlum					MD			5/18/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
DANIEL ROSENBLUM					10400 CONNECTICUT AV KENSINGTON MD 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation			5/19/82		Metropolitan Crematory		Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home, Inc.						MAY 24 1982		[Signature]		
1331 Rockville Pike Rockville, Maryland										

1 2 3 4 5 6 7 8 9 10 11 12

NOV 18 1952 3:33 a

1952

1952

01

NO

11

NO

white

female

Montgomery

X

USA

Mr. J. J. J.

Secretary of the

Independence

Rockville

Independence

X

Montgomery

Rockville

Box

A.

Kalen

Harlie

Clifford

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52 10-14-52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 2 2 9	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		2b. DATE OF DEATH		2c. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY GEORGIA DEAGRO						2a. DATE OF DEATH MONTH DAY YEAR 5-30-82		2b. DATE OF DEATH MONTH DAY YEAR 5-30-82		2c. DATE OF DEATH MONTH DAY YEAR 5-30-82	
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 26 30		6. AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7d. HOUR 7:40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Takoma				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-High's Dairy Stores			
13a. STATE Maryland				13b. COUNTY Prince George				13c. CITY OR TOWN Langley Park			
14. FATHER'S NAME FIRST MIDDLE LAST George Matthew Griffen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Cordelia Martinez				16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
17. STREET ADDRESS 1415 Quebec Street				18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES no ---				19. SOCIAL SECURITY NO. 577-40-1212			
20. INFORMANT Donna J. Ball same as 13c				21. ADDRESS				22. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-31-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/3/82				23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery			
23d. LOCATION CITY OR TOWN Rockville, Maryland				23e. COUNTY Rockville, Maryland				23f. STATE			
24. FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 4 1982				25b. REGISTRAR'S SIGNATURE			

BP

5600
DHMH - 17
(VR A15 ME (5))
20M 4/82

100000

white 1 2 3 4 5 6 7 8 9 10 11 12

George Washington University

577-10-1011

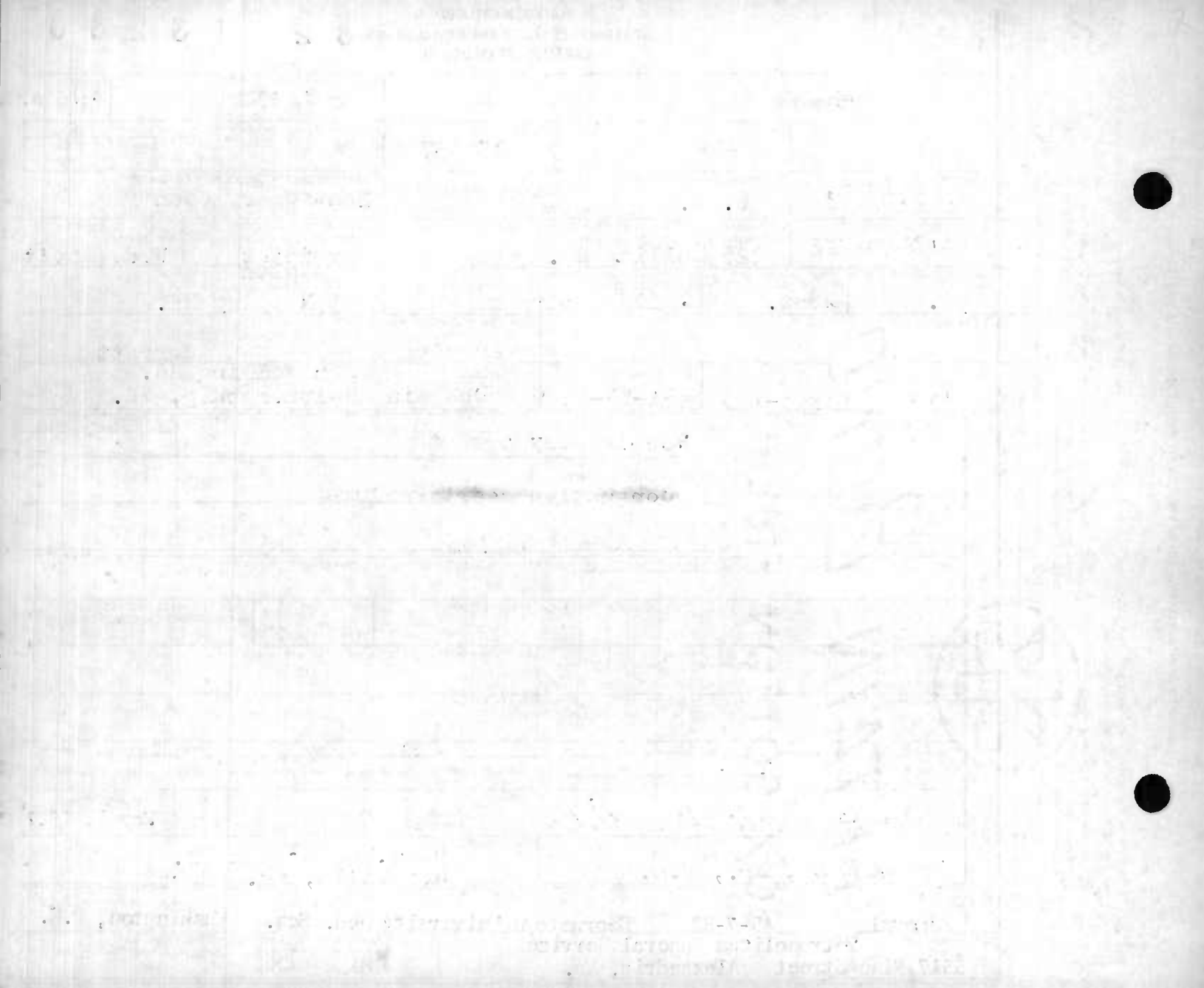
George Washington University
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 1 3 2 3 0 CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Hugh Edward DeSpain					2a. DATE OF DEATH MONTH DAY YEAR May 7, 1982			2b. HOUR 9:05 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 15 37		6. AGE (IN YEARS LAST BIRTHDAY) 44		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Joiner, Arkansas		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery county MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 225 Rolling Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Gaithersburg 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13e. STREET ADDRESS 225 Rolling Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita Barrett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 1955-1959 431-56-3389		17. INFORMANT Mary DeSpain		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a): Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c): Oligodendroglioma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from May 3 , 19 82 , to May 7 , 19 82 , that (I) two lost saw the deceased alive on May 6 , 19 82 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I we did not) (did not view the body after death).									
22b. SIGNATURE Frank Mate, Jr. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 7, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank Mate, Jr., M.D.						22e. ADDRESS 50 W. Edmonston Dr. Rockville, Md. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 5-7-82		23c. NAME OF CEMETERY OR CREMATORY Georgetown University Med. Sch.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service						25a. DATE REC'D. BY REGISTRAR MAY 12 1982			
25b. REGISTRAR'S SIGNATURE James J. [Signature]									
25c. ADDRESS 5517 Vine Street Alexandria, Va.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8 2 1 3 2 3 1						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Henry M. Detwiler, Jr.			5-17-82		6 a.		M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male		White		April 18, 1923		59 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.		Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		778 College Parkway				Serv. Representative		Kodak Co.	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		778 College Parkway	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Henry M. Detwiler, Sr.			Frances Taylor						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS	
Yes-W.W.II Army Air Force			218-16-6667			Glenore H. Detwiler		Address Same as No# 13e.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) PROSTATIC CANCER WITH									
1850 DUE TO, OR AS A CONSEQUENCE OF BONE METASTASES									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			P.M. 19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from APRIL 19 82 to MAY 17 19 82, that (I) we lost saw the deceased alive on MAY 17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.									
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
Alfred Muller, M.D.			M.D.					5-17-82	
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS						
Alfred Muller, M.D.			3301 New Mexico Ave. Washington, D.C.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-20-82		Ft. Lincoln Cemetery		Brentwood P.G. Maryland			
24 FUNERAL DIRECTOR NAME						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
F. Gasch's Sons F.H. P.A. Hyattsville, Md.						MAY 20 1982		Francis Van N...	

MEDICAL CERTIFICATION

F. Gasch's Room R.H. P. Hattaville, Md.

Quinn 5-20-70 F. Lincoln Cemetery Brentwood D.C. Maryland

Alfred Miller, N.D. 3701 New Mexico Ave. Washington, D.C.

x

Yes-1.11

Ray Air Force

219-10-2607

M. Detweiler, Sr.

Francis

Taylor

Address same as

Nov 1961

Maryland

Montgomery Rockville

x

778 College Parkway

Rockville

778 College Parkway

Geny. Representative Robert Co.

Maryland

U.S.A.

Montgomery

White

April 12, 1953

50

Henry

M.

Detweiler, Jr.

2-17-54

64

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Robert Koller DeVries			MONTH DAY YEAR May 7, 1982			10:50AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	MONTH DAY YEAR Aug. 11, 1908	73			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.	U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Olney	Montgomery General Hospital							
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Md.			Howard Mt. Airy			17771 Hardy Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST John O. DeVries			FIRST MIDDLE LAST EMMA Koller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			—			Virginia DeVries Mt. Airy, Md.		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY								18. PROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Hepatoma								imo
1550 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								5 yr
DUE TO, OR AS A CONSEQUENCE OF								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Hepatic Encephalopathy								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from Jan 19 79 to May 7 19 82, that (2) (we) lost saw the deceased alive on May 6 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Daniel L. Anderson			MD			5/7/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Daniel L. Anderson M.D.			1814 N. Philip Dr. Olney Md 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			5-10-82			Wesley Freedom Center		
23d. LOCATION (CITY OR TOWN) COUNTY STATE			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Sylvanville Carroll Md.			MAY 13 1982			Charles W. Haight		
24. FUNERAL DIRECTOR NAME ADDRESS			24b. DATE REC'D. BY REGISTRAR			24c. REGISTRAR'S SIGNATURE		
Harry W. Haight Sylvanville, Md.			MAY 13 1982			Charles W. Haight		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified to complete the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to complete the certificate.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 2 3 3					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eula F. Dickerson</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>May 26, 1982</i>				2b. HOUR <i>527 P.M.</i>	
3. SEX <i>FEMALE</i>			4. RACE <i>CAUCASIAN</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>APRIL 4, 1897</i>			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>85</i> YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>SOUTH CAROLINA</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.						
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>PRI. GEORGES</i>			13c. CITY OR TOWN <i>HYATTSVILLE</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>8011 RIGGS ROAD 20783</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM N. FOUNTAIN</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH L. GRIFFIN</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>046-14-8193</i>			17. INFORMANT <i>GERALDINE SMITH</i>			ADDRESS <i>SAME AS 13</i>			DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Negative Autopsy</i> <i>5751</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Renal failure and D.I.C.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis, probably cholangitis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-6 day</i> <i>6-8 day</i> <i>10-12 day</i>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (if this hospital) attended the deceased from <i>5/26</i> to <i>5/26</i> , 19 <i>82</i> , that (if) (we) last saw the deceased alive on <i>5/26</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Martha Eichen</i>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5/27/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Eichen</i>				22e. ADDRESS <i>3915 Jenkins Dr. Wheat</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>5/30/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WEST VIEW CEMETERY</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>AUGUSTA RICHMOND GEORGIA</i>					
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>						ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>					

1885

1885

1885

1885

1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 3 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM N. DICKERSON				2a. DATE OF DEATH MONTH DAY YEAR MAY 24 1982		2b. HOUR 8 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 11 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 777 Briggs Chaney Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planner Estimator		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David Dickerson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Hawes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS 777 Briggs Chaney Rd. Mary Dickerson Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4140						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS. YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5/15 , 19 82 , to MAY 25 , 19 82 , that (we) lost saw the deceased alive on 5/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold W. Draper M.D.				DEGREE M.D.		22c. DATE SIGNED 5/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.				22e. ADDRESS 9801 GEORGIA AVE. SILVER SPRING, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/27/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.				P.O. Box 7428 ADDRESS Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR JUN 1 1982	
				25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 2 3 5			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CLARA E. DIXON				2a. DATE OF DEATH MONTH DAY YEAR 5. 19. 82		2b. HOUR 10:50 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 28 03		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRI. GEO. 13c. CITY OR TOWN HYATTSVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 904 LINWOOD STREET 20783	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MATTHEWS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILY MEYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-01-2950		17. INFORMANT ADDRESS LAWRENCE F. BECK SON-IN-LAW SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Stem Stroke				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days			
2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Chronic Lymphocytic Leukemia 2 years			
				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALONE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1980 19 82 to 1980 19 82 , that (I) (we) lost saw the deceased alive on 1980 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE [Signature]		22c. DATE SIGNED 20 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael L. Berkowitz, M.D.				22e. ADDRESS 1120 New Hampshire Ave S.S., Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/24/82		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR MAY 24 1982 REGISTRAR'S SIGNATURE Francis J. Collins			

THE UNIVERSITY OF CHICAGO
LIBRARY

3

3 3 3 3

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			7b HOUR		
James J. Doran			5 21 82			6:30P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	2 FEB 2 10	72			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Scotland	USA				Montgomery MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Olney	Montgomery General Hospital			Electrician			Elec. Co..	
13a STATE			13b CITY OR TOWN			13c STREET ADDRESS		
Maryland			Baltimore			3 Beehive Place		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Thomas - MIDDLE Doran LAST			Helen - MIDDLE McCafferty LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
yes (IF YES, GIVE YEAR OR DATES) WWII			046-01-1195			Elizabeth C. Doran Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - pulmonary arrest</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hiatal Hernia + Reflux Esophagitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 10 years 2 years								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>April 24</u> , 19 <u>82</u> , to <u>May 21</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>May 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)								
22b. SIGNATURE			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
			MD					5/21/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Lewis Kellert, MD			1811 Prince Philip Dr. Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial			May 26, 1982			Laytonsville		Laytonsville Mont. Md.
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR					
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879			MAY 26 1982					

U. S. DEPT. OF JUSTICE

RECEIVED

x

Office

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 3 7			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
EDWARD FREDERICK DOWNS				5 10 82				6:30 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		OCT 21, 1917		64 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
KENTUCKY		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL				ATTORNEY		F.T.C.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND				MONTGOMERY		BETHESDA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7601 SEBAGO ROAD 20817	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
EDWARD BOYD DOWNS				MAY BLACKFORD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES				WW II		CATHERINE DOWNS		SAME AS 13 WIFE			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>far advanced chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cigarette smoking</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>probable infection - lung</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>1980</u> 19____, to <u>5/10/82</u> 19____, that (1) (we) last saw the deceased alive on <u>5/10/82</u> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Elmer R. Goldstein</u>				M.D.				5/11/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ELMER R. GOLDSTEIN				9410 OLD GILBERTOWN RD				BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		5/13/82		ARLINGTON NATIONAL		ARLINGTON		MONTGOMERY		VIRGINIA	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS				MAY 17 1982				<u>James J. [Signature]</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DMMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rose Dubinsky			2a. DATE KNOWN OF DEATH ESTIMATED May 29, 1982			2b. HOUR 12:12		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD May 29, 1982	2d. HOUR 12:12		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11206 Lockwood Dr. Apt 1220			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Leo Stein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Chasetz		13e. STREET ADDRESS Oak Leaf Dr. Apt 1220				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 056-22-2608		17. INFORMANT ADDRESS Morton Dubinsky-son-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) DPM		MEDICAL EXAMINER		DATE May 29, 1982		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1919 Seminary Rd., S.S. Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-30-1982		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE Thomas Van Natta		
ADDRESS Sil. Spr. Md.								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		THEODORE S. DUNHAM										2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR																			
1. DECEASED NAME (TYPE OR PRINT)		Theodore S Dunham										2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH		11. DAY		12. YEAR		13. HOUR																			
3. M		4. W.		5. Aug 7 92		6. 89 YRS.		7. MONTHS		8. DAYS		9. May 4 1982		10. MONTH		11. DAY		12. YEAR		13. 9:20 P.M.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																											
7a. Ohio				7b. USA								9. Montgomery MD.																											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																																			
10. Tak Park				11. Wash Advent Hosp																																			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)																							
12a. Md																12b. SPO.																							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS																							
13a. Md				13b. Montg				13c. Tak Park				13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. 6607 Westmoreland Ave																							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																																			
14. Charles				15. Elizabeth Small																																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)																16b. SOCIAL SECURITY NO.				17. INFORMANT				18. ADDRESS															
16a. Yes																16b. WWT				17. Gladys M. Dunham				18. (Daughter)															
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																							
PART 1 DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Acute Myocardial Dis.																																							
4391																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(b) Chronic Myocardial Dis.																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)																			
										P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
																				STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE																			
John P. Rogers										M.D. M.D.										MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Burial										May 7 1982										St. Lucius										Baltimore, Md.									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
William Walters										MAY 7 1982										James J. W. Walters																			

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 3 2 4 0

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Celius Duvall			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1982			2b. HOUR MIN. 11:51 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Mt. Airy Apts, No. 56	
14. FATHER'S NAME FIRST MIDDLE LAST Clinton Duvall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Exie Mullinix							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 212-36-8410		17. INFORMANT ADDRESS Elizabeth Wirth Duvall, Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Charles A. Gelber, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/5/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Gelber, M.D.						22e. ADDRESS Montgomery General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., ADDRESS Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAY 10 1982				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

7
1000
x

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 2 4 1		
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Florence Milburn Ennis					2a. DATE OF DEATH MONTH 5 DAY 21 YEAR 82		2b. HOUR 12:35 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 20 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUBURBAN SET ADDRESS) SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2008 Baltimore Road						
14. FATHER'S NAME FIRST William MIDDLE Milburn LAST Ennis				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Moore LAST Ennis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 226-62-9482		17. INFORMANT ADDRESS Louise Montague 10500 West Lake Dr. Bethesda						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto. Degenerative Failure 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic severe emphysema DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MI.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHF, chronic suppurative												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19 5/21 , 19 82 , that (I) (we) last saw the deceased alive on 5/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Camina		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/21/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILHELMINA CAMINA				22e. ADDRESS 9412 ADRIAN ST Rockville MD 20852								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/82		23c. NAME OF CEMETERY OR CREMATORY Mt Comfort		23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Co., Virginia						
24. FUNERAL DIRECTOR Walter J. Hall Cameron & Alfred Sts. Cunningham Funeral Home, Inc., Alex., Va.						25a. DATE REC'D. BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE [Signature]				

BP

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 2 1 3 2 4 2				
CERTIFICATE OF DEATH					REG. NO.				
DECEASED NAME (TYPE OR PRINT) WILMA C ENRIGHT					2a. DATE OF DEATH MONTH DAY YEAR 5 22 82 7b. HOUR 850 PM				
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 27 93		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 08	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor		12b. KIND OF BUSINESS OR INDUSTRY Appliance Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13e. STREET ADDRESS #1 Primrose St.			
14. FATHER'S NAME FIRST MIDDLE LAST James Cullinan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Weber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 217-32-1359		17. INFORMANT ADDRESS Maryland. James R Enright 9700 Culver St., Kensington		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia left lower lobe 4850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5/22/82 to 5/22/82 , that the (we) last saw the deceased alive on 5/22/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did not) view the body after death.									
22b. SIGNATURE Robert C. Macon M.D.						DEGREE M.D.		22c. DATE SIGNED 5/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon						22e. ADDRESS 809 Wiers Mill Rd. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/25/1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland		
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.						25a. DATE REC'D. BY REGISTRAR MAY 26 1982			
NAME 5130 Wisc. Ave., N.W. Wash., D.C.						25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

XX

U.S.A.

and Britain

I believe

now

Monday

11

1962

11/11/62

11/11/62

11/11/62

11/11/62

11/11/62

11/11/62

11/11/62

11/11/62

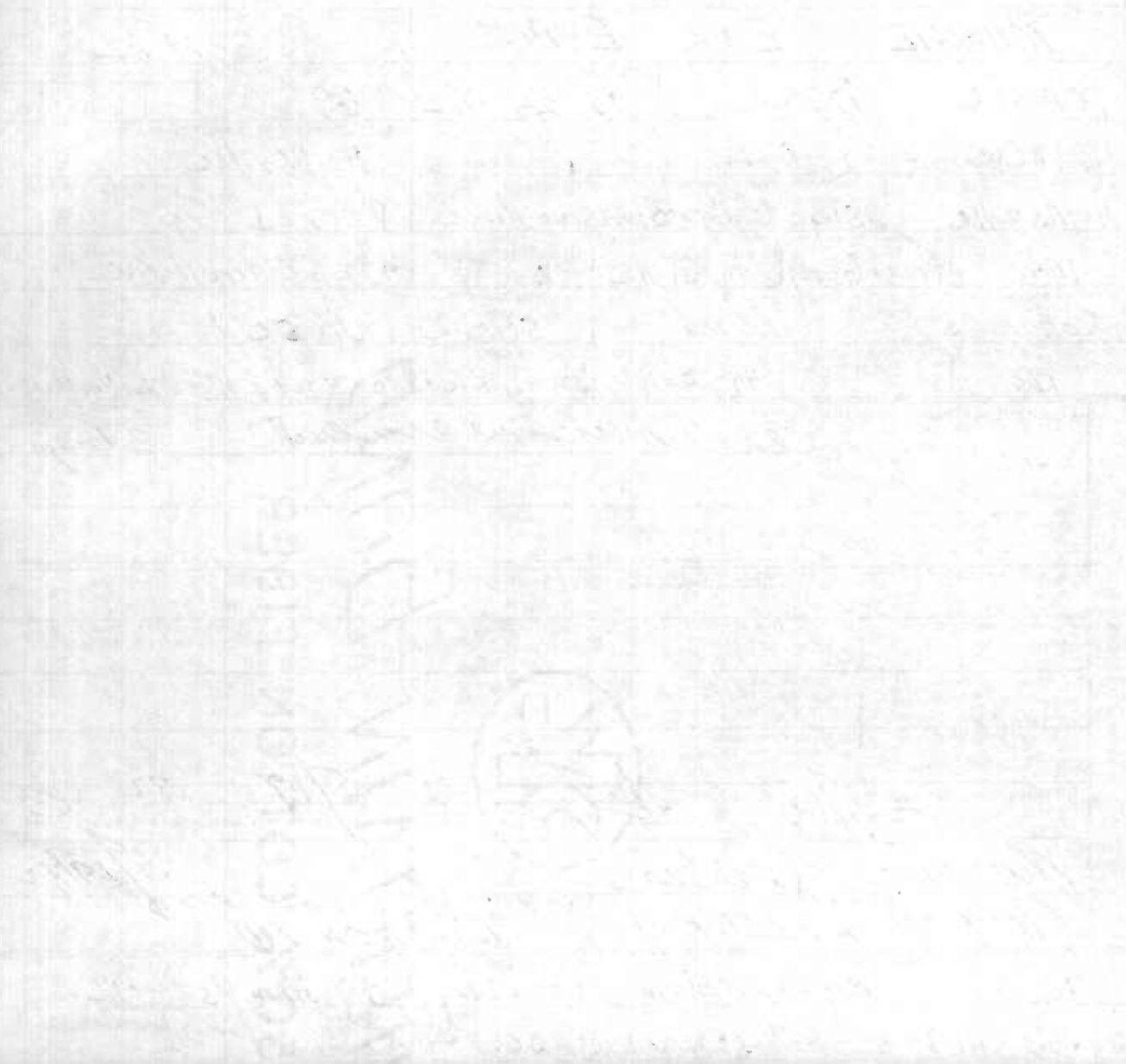
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified and a post-mortem examination may be required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1- FOR STATE REGISTRAR		8 2 1 3 2 4 3				REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) MAGGIE E EVANS					2a DATE OF DEATH MONTH DAY YEAR 5 19 82			2b HOUR M 			
3 SEX Female		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 24 1912		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Haythsville Mont. MD.					
10 CITY OR TOWN OF DEATH Haythsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE MD.					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS 7725 Carroll Ave.				
14 FATHER'S NAME FIRST MIDDLE LAST George NUNN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie UINSON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 244-126106		17 INFORMANT ADDRESS Donald Ricardo 5909 EASTMAN Ave Haythsville MD.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4360 IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 5/25 19 82 , to 5/19 19 82 , that (he) (we) lost (saw) the deceased alive on 5/19 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) (see) the body after death.											
22b. SIGNATURE Myron L. Lenkin			DEGREE			22c. DATE SIGNED 5/19/82		22d. ADDRESS 2309 Shorefield Rd WHEATON, MD			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN			22f. ADDRESS 2309 Shorefield Rd WHEATON, MD			22g. LOCATION CITY OR TOWN COUNTY STATE WILSON Mills N.C.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE MAY 23, 1982			23c NAME OF CEMETERY OR CREMATORY Family Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Wilson Mills N.C.		
24 FUNERAL DIRECTOR NAME Watson F.H.			24b ADDRESS 3435-14th St N.W. WASH.D.C.			25a DATE REC'D. BY REGISTRAR JUN 11 1982				25b REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

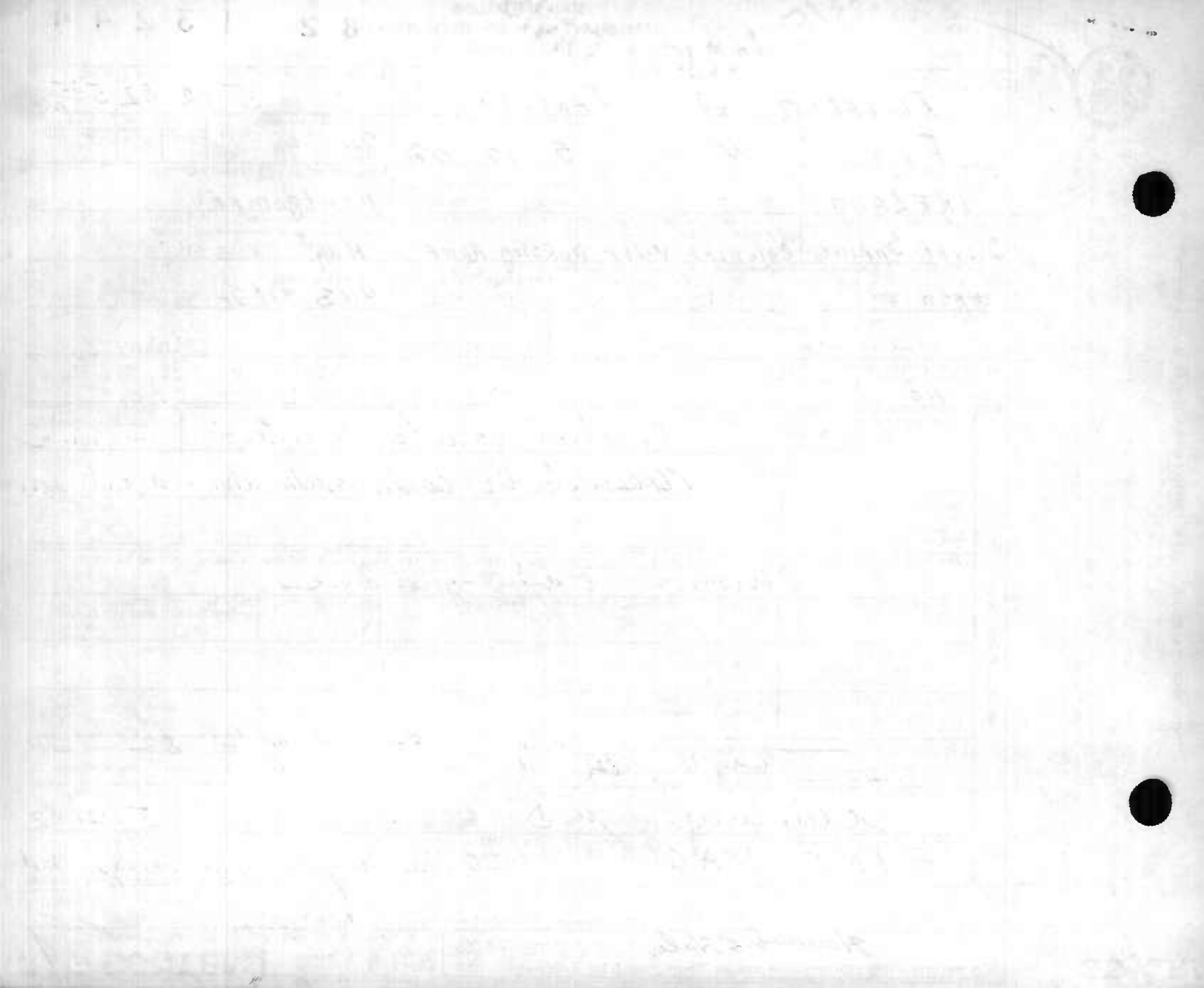
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be consulted at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH J FANCHER			2a. DATE OF DEATH MONTH 5 DAY 12 YEAR 82			2b. HOUR 5:35 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 5 DAY 17 YEAR 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE XXXXXX		13b. COUNTY Wash., D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4118 3rd St., N. W.	
14. FATHER'S NAME FIRST Alexandria MIDDLE Doak LAST Finlay		15. MOTHER'S MAIDEN NAME FIRST Hannah MIDDLE Finlay LAST Finlay		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-62-0098	
17. INFORMANT Earl Fancher Washington, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) several years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic brain syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from July 1980 to May 12 1982 , that (1) (was) last saw the deceased alive on May 11 1982 and that in (my) (best) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE EINO MAGI		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EINO MAGI		22e. ADDRESS 11120 New Hampshire Ave., Sil. Spr., Md.		23a. LOCATION CITY OR TOWN COUNTY STATE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Md.	
24. FUNERAL DIRECTOR NAME Howard E. Warner ADDRESS P.O. Box 7428		25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE Ph...			
Warner E. Pumphrey, Inc., Sil. Spr., Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 2 4 5	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA FARACE			2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1982		2b. HOUR 3 40 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 20 20		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D C		13b. CITY OR TOWN Wash. D C	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 919 Perry Place. N E	
14. FATHER'S NAME FIRST MIDDLE LAST Enrico Monico		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Concetta Ditonna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 579 58 2399		17. INFORMANT ADDRESS Nicola Farace (husband) Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 1579 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) of the pancreas					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/29 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 982 5/4 82	
22a. I certify that (I) (this hospital) attended the deceased from 4/29 , 19 82 , to 5/4 , 19 82 , that (I) (we) last saw the deceased alive on 5/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph Solinas		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Solinas		22e. ADDRESS 9801 Georgia Ave. S S Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE S S Mont. Maryland					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		24b. ADDRESS 11800 N H Ave. S S Md.		25a. DATE REC'D. BY REGISTRAR MAY 6 1982	
		25b. REGISTRAR'S SIGNATURE Frances Santhorne			

13. 11. 1913

Dear Sir,

I have the pleasure to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours faithfully,

W. J. H. [Signature]

Enclosed for you are the same as before.

I am, Sir, very respectfully,
Yours faithfully,

W. J. H. [Signature]

I am, Sir, very respectfully,
Yours faithfully,

W. J. H. [Signature]

I am, Sir, very respectfully,
Yours faithfully,

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	3	2	4	6
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) HANS G. FIEDLER										2a. DATE OF DEATH MONTH DAY YEAR MAY 18 '82				2b. HOUR 1 PM		
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 12 1904				6. AGE IN YEARS LAST BIRTHDAY 78		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.								
10. CITY OR TOWN OF DEATH Bethesda,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Retirement & Nursing Center								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Textiles				
13a. STATE Pennsylvania				13b. COUNTY Berks		13c. CITY OR TOWN Reading		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1401 Ridge Avenue						
14. FATHER'S NAME FIRST MIDDLE LAST Paul Fiedler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) yes WW 2				16b. SOCIAL SECURITY NO. 170 07 2786		17. INFORMANT Germantown, Maryland John B. G. Fiedler, 15701 Seneca Road,										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1579										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, lung 1 year																
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, PANCREAS 2 "																
DUE TO, OR AS A CONSEQUENCE OF (c) 																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from APRIL 4/82 to 5/18/82 . That (I) (we) last saw the deceased alive on 5/12/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Thos G. Ward MD DEGREE MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/18/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD										22e. ADDRESS 6116 ROBINWOOD, BETHESDA, 20817						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia								
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A., Bethesda, Maryland										25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Thos G. Ward				

BP

0 1 2 3 4 5 6

THE UNIVERSITY OF CHICAGO

Handwritten notes and signatures at the top of the page.

Handwritten notes in the middle section of the page.

Handwritten notes in the lower middle section of the page.

Handwritten notes and diagrams in the bottom section of the page.

Handwritten notes and signatures at the bottom of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 2 4 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MATVEY			2a. DATE OF DEATH 5/15/82			2b. HOUR 12:13 AM			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH JAN. 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? NONE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUREAUCRAT		12b. KIND OF BUSINESS OR INDUSTRY RUSSIAN GOV'T.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST LEIB FINKELSHTEYN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNK)		16. STREET ADDRESS 6121 Montrose Road; Rockville, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 094-62-6615		17. INFORMANT 215 Rollins Avenue, T-3; Rockville, Md. SERGEY LYUBSKY; Grandson-In-Law;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coma etiology? DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. IF OPERATION?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (STATE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/10/82 , 19 82 , to 5/15/82 , 19 82 , that (I) (we) last saw the deceased alive on 5/15/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hen. D. Khutney		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY D. KHAMNEY		22e. ADDRESS Suburban Hosp - Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emmes		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. ADDRESS 1170 Rockville Pike; Rockville, Maryland		25b. RECEIVED BY REGISTRAR MAY 19 1982		25c. SIGNATURE Harold J. [Signature]	

MEDICAL CERTIFICATION

11. 12. 1941



11. 12. 1941

Handwritten notes and sketches, including a large 'X' and a circle.



BP
DHMH - 17
(V) R A15 ME (51)
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 2 4 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS ALFRED FISCHER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR MAY 30, 1982	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1910		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MAY 30, 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12815 EVANSTON STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESTAURANT OWNER		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12815 EVANSTON STREET	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. FISCHER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY M. CODY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-10-6711		17. INFORMANT ADDRESS MARJORIE SPRUILL (NIECE) SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 METASTATIC CARCINOMA OF LIVER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) DEPUTY				DATE SIGNED MAY 30, 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN TAUBER				ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JUNE 3, 1982		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS SILVER SPRING, MD.		25a. DATE BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 1 3 2 4 9

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) JOHN CHARLES FISHER, JR.			2a DATE OF DEATH MONTH DAY YEAR MAY 26, 1982			2b HOUR 5:30pm				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 9 1926		6 AGE (IN YEARS LAST BIRTHDAY) 56		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b KIND OF BUSINESS OR INDUSTRY Farming		
13a STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Glenwood		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2840 Hobbs Road		
14 FATHER'S NAME FIRST MIDDLE LAST Leonard K. Fisher				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosaline E. Dooley						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. 218/30/6306		17 INFORMANT Ruth Ann Fisher				ADDRESS 2840 Hobbs Road Glenwood MD 21738	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1889 METASTATIC BLADDER CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 82 to May 26 19 82 that (I) (we) last saw the deceased alive on May 26 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Eugene P. Flannery, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED MAY 26, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY					22e ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD. 20832					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/29/1982		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville HO MD		
24 FUNERAL DIRECTOR NAME SLACK FUNERAL HOME					ADDRESS PO Box 268 Ellicott City 21043		25a DATE REC'D. BY REGISTRAR MAY 28 1982			
					25b REGISTRAR'S SIGNATURE Thomas J. Fisher					

35
69
30
2

1. The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

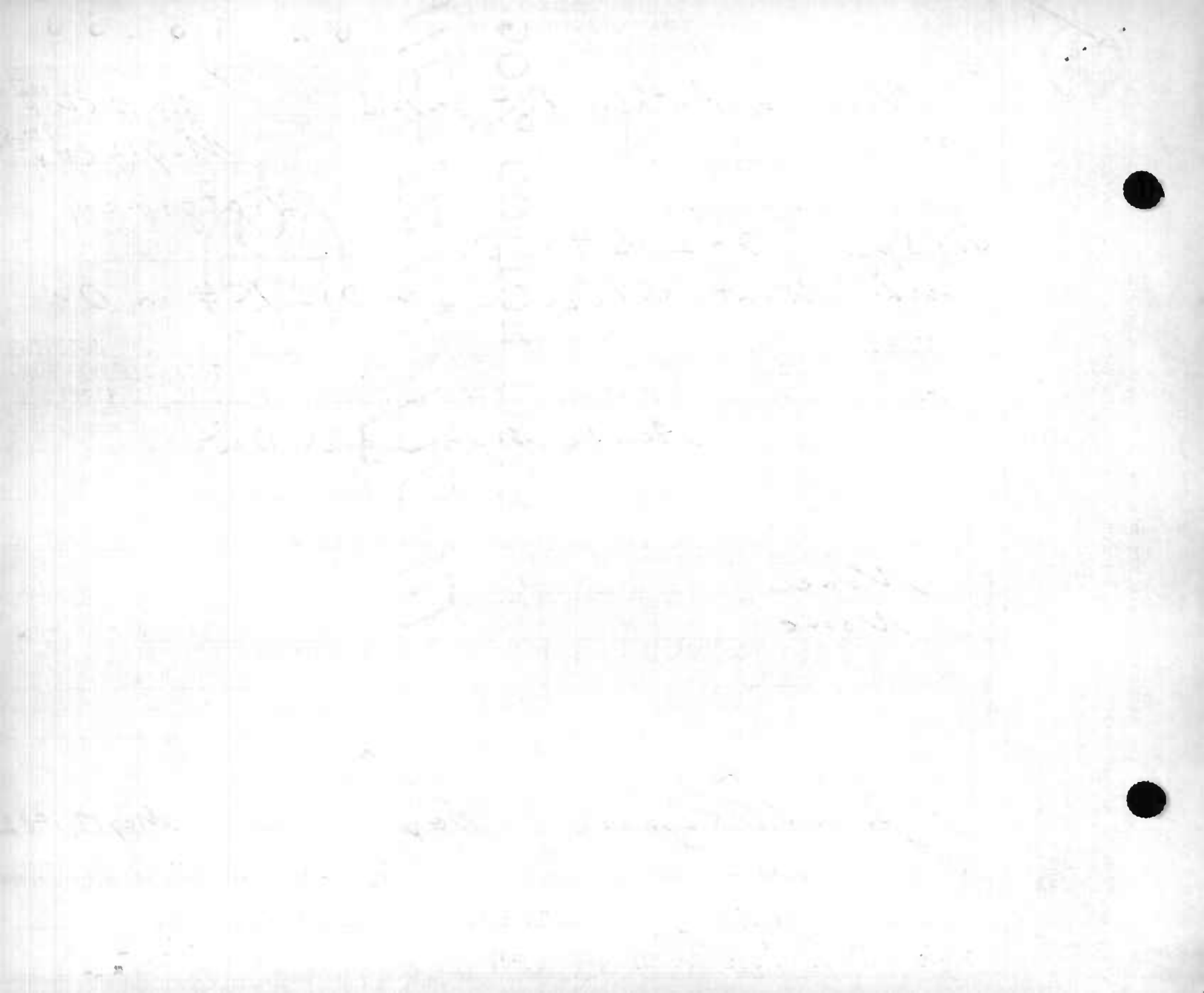
100-100000-100000

100-100000-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13250	
1. DECEASED NAME (TYPE OR PRINT) Nicholas Anthony Fitzgerald						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR May 12, 1982		2b. HOUR 10:05			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR DEC 3, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD May 12, 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 Patton Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 202 Patton Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM R. FITZGERALD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA E. HUTCHINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WWW 11		17. INFORMANT SISTER		ADDRESS 7045 BASSWOOD ROAD FREDERICK, MD. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Dep				DATE SIGNED May 13, 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Francis J. Collins			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						MAY 17 1982					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 2 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) PATRICK JAMES FITZGIBBONS				2. DATE OF DEATH MONTH DAY YEAR 5/15/81				3. HOUR 8:00 P.M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT 29, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. # UNDER 1 YEAR MONTHS DAYS		8. # UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN YOUR CARE, GIVE STREET ADDRESS) GARFIELD NURSING CENTER 9101 SECOND AVE. SILVER SPRING, MD.				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2908 BLUERIDGE ROAD 20902	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES FITZGIBBONS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN LYNCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 578-32-1086		17. INFORMANT EUGENE G. FITZGIBBONS				17. ADDRESS SAME AS 13 SON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLERA C ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) DECOMPOSING HEMORRHOIDAL/EDSWA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) ABNOR + HYPERTENSIVE CVO										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): none											
19a. DATE OF OPERATION W/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED W/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) W/A							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 779 5/15 81							
22a. I certify that (X) (this hospital) attended the deceased from above, (b) (we) did not view the body after death.											
22b. SIGNATURE [Signature]				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/15/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL MARGOLIS				22e. ADDRESS 11404 OLD GEORGETOWN RD. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/19/82		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE [Signature]					

BP.

1 2 3 4 5 6 7 8 9 10 11 12

Formal letter to the

Dear Sir,

I am writing to you

Yours faithfully

12/12/1911

12/12/1911

12/12/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	3	2	5	2			
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH									
I. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH									
FIRST MIDDLE LAST HUGH V. FRANCIS										MONTH DAY YEAR HOUR MAY 16 82 6:00 PM									
3. SEX MALE			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR DEC 6, 1896			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.										
10. CITY OR TOWN OF DEATH KENSINGTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3603 LAWRENCE AVENUE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER			12b. KIND OF BUSINESS OR INDUSTRY DIAMOND TAXI CO.										
13a. STATE MARYLAND										13b. COUNTY MONTGOMERY			13c. CITY OR TOWN KENSINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT FRANCIS										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMY YATES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-1183			17. INFORMANT NANCY L. DUNN			ADDRESS SAME AS 13 DAUGHTER										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Malignant Melanoma - Right Eye</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1975</u> to <u>May 16, 1982</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Morton A. Schuler MD										DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/16/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton A. Schuler MD										22e. ADDRESS 1299 - Cambridge Springs Rd.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/20/82			23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN			23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.										
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS										ADDRESS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901			25. DATE REC'D. BY REGISTRAR MAY 19 1982				REGISTRAR'S SIGNATURE Francis J. Collins		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHHM - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 21a shows any injury, or other traumatic event, the medical examiner must be notified.

Cleared by DR. MAYLE

FOR 1. STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 2 5 3 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MAREIDA P. Frederick										2a. DATE OF DEATH MONTH DAY YEAR 5/8/82										2b. HOUR 1:55 P.M.									
3. SEX Female					4. RACE Caucasian					5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1903					6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania					7b. CITIZEN OF WHAT COUNTRY? United States					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.														
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker					12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. STATE Maryland					13b. CITY OR TOWN Montgomery					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS 10250 Westlake Drive														
14. FATHER'S NAME FIRST MIDDLE LAST George F. Vogel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Brierly					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 177-38-8649					17. INFORMANT William W. Frederick Potomac, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Arrest 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Heart Disease with Recent Myocardial Infarction																													
19a. DATE OF OPERATION 4/30/82					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carotid Artery Stenosis (RT)					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from 5/8 , 19 82 , to 5/8 , 19 82 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 5/8 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.																													
22b. SIGNATURE Harris M. KENNEDY MD										DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5/8/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRIS M. KENNEDY MD										22e. ADDRESS 10401 Old Georgetown Rd Bethesda MD 20814																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE May 9, 1982					23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.					23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia														
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey										ADDRESS Homes, P.A. Bethesda, Maryland					25a. DATE RECD. BY REGISTRAR MAY 13 1982					25b. REGISTRAR'S SIGNATURE James O. N. Th...									

2008-1-26

MAINTENANCE REPORT

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26

2008-1-26



Released by Mr. Paulsen for Mr. Mayfield

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 2 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theodore NMI French			2a. DATE OF DEATH MONTH DAY YEAR 5.25.82.			2b. HOUR 11:15PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY US GOVT.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 10500 Rockville Pike			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick F. French			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cordelia Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 129-14-8117		17. INFORMANT Katharine D. French Same as Item # 13				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Myocardopathy</u> (c) <u>1 year.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jesse Samuels			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JESSE D. SAMUELS, MD.			22e. ADDRESS SUBURBAN HOSP - BETHESDA							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/27/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C.					25a. DATE REC'D. BY REGISTRAR JUN 2 1982					
					25b. REGISTRAR'S SIGNATURE Francis J. Smith					

BP

42581 20

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1- FOR STATE REGISTRAR					8 2 1 3 2 5 5						
CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) CELIA FRIEDMAN					2a. DATE OF DEATH MONTH DAY YEAR MAY 29 1982					2b. HOUR 4:25 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MARCH 18 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) London, England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6121 Montrose Road			
14. FATHER'S NAME FIRST MIDDLE LAST Hyman Rudolph				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Student							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-74-4160		17. INFORMANT ADDRESS Silver Spring, Md. Donald Friedman; 9702 Dameron Drive;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary failure 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe dementia.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 1/29 , 19 73 , to 5/29 , 19 82 , that (we) lost saw the deceased alive on 5/29 , 19 82 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I we) (did) (did not) view the body after death.											
22b. SIGNATURE K. H. Shah MD					DEGREE MD			22c. DATE SIGNED 5/29/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. SHAH MD					22e. ADDRESS 6121 Montrose Road Rockville						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY Children of Israel		23d. LOCATION CITY OR TOWN COUNTY STATE Youngstown; Mahoning; Ohio				
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS					25a. DATE REC'D. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE Ramon J. [Signature]				
1170 Rockville Pike; Rockville, Maryland 20852											

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the report. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The organization of the report is as follows: Introduction, Experimental, Results, Discussion, and Conclusion.

2. The second part of the report is the experimental section. It describes the apparatus and materials used, the procedure followed, and the results obtained. The apparatus used includes a reaction flask, a thermometer, a stop watch, and a gas syringe. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The procedure followed is to mix known volumes of hydrogen peroxide and potassium iodate in a reaction flask, add a known volume of sulfuric acid, and measure the volume of gas evolved at different temperatures. The results obtained are as follows:

3. The third part of the report is the results section. It presents the data obtained from the experiment and discusses the results. The data are presented in the following table:

Temperature (°C)	Volume of Gas Evolved (cm ³)
20	10.0
30	15.0
40	25.0
50	40.0

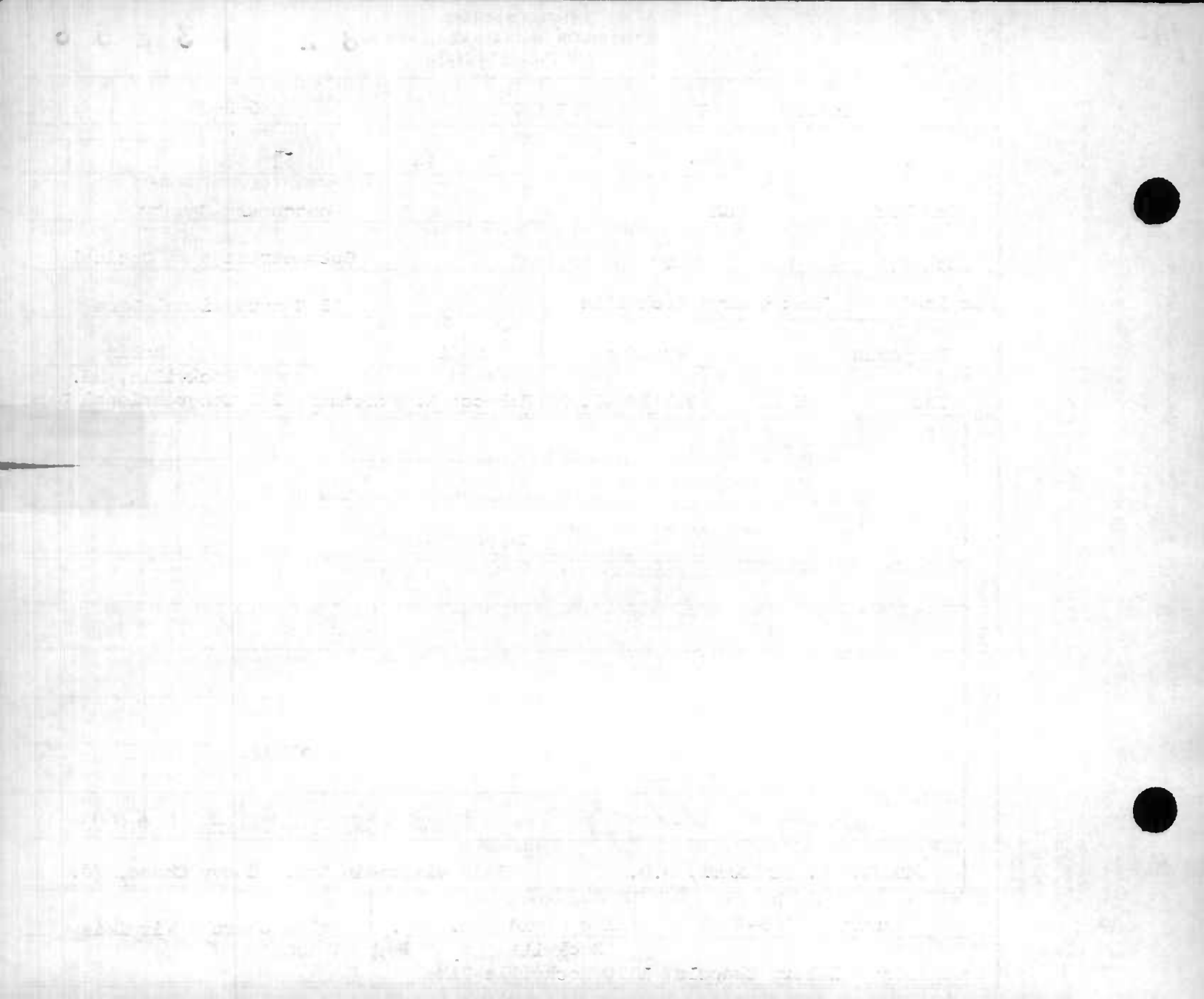
The results show that the rate of reaction increases with increasing temperature. This is expected, as the rate of reaction increases with increasing kinetic energy of the molecules. The activation energy of the reaction can be determined from the slope of the graph of $\ln k$ versus $1/T$.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 5 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH J FRIEDMAN				2a. DATE OF DEATH MONTH DAY YEAR 5-2-82		2b. HOUR 4:00A _M	
3. SEX M		4. RACE Caus.		5. DATE OF BIRTH MONTH DAY YEAR 1 1 20		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Optometrist		12b. KIND OF BUSINESS OR INDUSTRY Optical	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Friedman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Rubin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 082-14-4305A		17. INFORMANT ADDRESS Rockville, Md. Rebecca A. Friedman; 263 Congressional Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>HYPERTENSION</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>82</u> , to <u>5/1/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stanley A. Schwartz</u> M.D.				22c. DATE SIGNED 5/1/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY A. SCHWARTZ, M.D.	
22e. ADDRESS 5454 Wisconsin Ave., Chevy Chase, Md.				22f. MEDICAL EXAMINER'S SIGNATURE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25. REC'D. BY REGISTRAR 25/ 5 1982			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 2 1 3 2 5 7	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret D. GALLOWAY					2a. DATE OF DEATH MONTH DAY YEAR 5-17-82			2b. HOUR 12 NOON			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 20 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife Own Home			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Wash., D.C.					13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1206 Holly Street, N. W.		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Donavan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Shields						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 220-54-2378		17. INFORMANT ADDRESS Joan Fletcher 11302 Rolling House Rd. Rockville, Md. 20852				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Porta Hepatis Obstruction DUE TO, OR AS A CONSEQUENCE OF (c) 4520 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/13 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/14 19 82 to 5/17 19 82 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 5/14 19 82 , and that (in my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.											
22b. SIGNATURE Michel M. Healy MD						22c. DATE SIGNED 5/17/82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS Michel M. HEALY MD 5652 Shields Drive Bethesda, MD 20817		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.			
24. FUNERAL DIRECTOR NAME Howard D. Hale						P.O. Box 7428 Warner E. Pumphrey, Inc. Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR MAY 20 1982		25b. REGISTRAR'S SIGNATURE Charles Jean Walker	

BP

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 8 2 1 3 2 5 8									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JENNIFER VICTORIA GARCIA						2a DATE OF DEATH MONTH DAY YEAR MAY 15 1982		2b HOUR 8:11p _M	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MAY 12 1982		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 3		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a		12b KIND OF BUSINESS OR INDUSTRY n/a	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE DELEWARE		13b COUNTY KENT		13c CITY OR TOWN DOVER		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 123-A WILLIS ROAD	
14 FATHER'S NAME FIRST MIDDLE LAST ANIEL GARCIA JR.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA VICTORIA SINDO					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. None		17 INFORMANT 123-A WILLIS ROAD ANIEL GARCIA DOVER, DELEWARE 19901			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 7684 DUE TO, OR AS A CONSEQUENCE OF (b) PRENATAL ASPHYXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from 12 MAY 1982, to 15 MAY 1982, that (if (we) lost saw the deceased alive on 15 MAY 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) did) (did not) view the body after death.									
22b SIGNATURE James W. Thorpe				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 17 MAY 1982	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. THORPE, CDR, MC, USN				22e ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE May 17, 1982		23c NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences, Bethesda, Maryland		23d LOCATION COUNTY STATE			
24 FUNERAL DIRECTOR NAME Capitol Funeral Service				ADDRESS Falls Church, Va.		25a DATE REC'D. BY REGISTRAR MAY 19 1982		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
7 2 1 3 2 5 9									
1 - FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERDIE INEZ GEARHART						2a. DATE OF DEATH MONTH DAY YEAR MAY 30, 1982		2b. HOUR 11:15 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 8, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ROCKVILLE, PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16704 BUCKNELL DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST NICHOLAS BERRY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BEES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-36-5439		17. INFORMANT ADDRESS Chaplain Richard G. Hambrick			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma to Liver 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE [Signature]						22c. DATE SIGNED 5-30-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]	
22e. ADDRESS						22f. DATE REC'D. BY REGISTRAR JUN 4 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-30-82		23c. NAME OF CEMETERY OR CREMATORY Georgetown University		23d. LOCATION CITY OR TOWN STATE Med. School Washington, D.C.			
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service 5517 Vine Street Alexandria, Va.						25. REGISTRAR'S SIGNATURE [Signature]			

UNCLASSIFIED

NO FOREIGN DISSEM

2017 Jan 2017
Classification Authority Expires
2-1-2017

2017 Jan 2017

Items #1a-22a Film G568 6/30/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 5 11 1982 2b. HOUR M 11:08

3. SEX male 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR Dec. 30, 1956 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York 7b. CITIZEN OF WHAT COUNTRY? U. S. A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.

10. CITY OR TOWN OF DEATH Takoma Park 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aide 12b. KIND OF BUSINESS (HANDLER OR RETAILER) Retarded Children.

13a. STATE New York 13b. COUNTY Chenango 13c. CITY OR TOWN Norwich 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 321-A., R.D.2., Manley Rd.

14. FATHER'S NAME FIRST MIDDLE LAST Clare Henry Gibbs 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan -- Shadle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS 321-A., R.D.2., Clare Henry Gibbs-Manley Road, Norwich, N.Y. 13815

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: 3040 IMMEDIATE CAUSE (a) Acute Heroin Intoxication
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Virginia L. Dolan M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5/12/82

EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street, Balto, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 5/14/82 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland (Pr. Geo's) Md.

24. FUNERAL DIRECTOR Richard A. Coleman-Upper Marlboro, Maryland 20772 25a. RECEIVED BY REGISTERAR'S SIGNATURE MAY 21 1982 James J. Nathan

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

• • •

ebj

• • • • •

• 37 •

1998

naot.

add to

Yves!

1961-1962

2007-08-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 2 6 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY F. GOLDBERG				2a. DATE OF DEATH MONTH DAY YEAR MAY 8, 1982		2b. HOUR 9:05 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE FELDMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA LUSTGARTEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 056-01-1812		17. INFORMANT ADDRESS 1538 RED OAK DRIVE JOSEPH G. GOLDBERG, SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) severe coronary artery disease - DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/6 , 19 82 , to 5/8 , 19 82 , that (I) (we) last saw the deceased alive on 5/8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Joseph M. Solinas				DEGREE MD		22c. DATE SIGNED 5/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS, MD.				22e. ADDRESS 9801 GEORGIA AVENUE, SILVER SPRING, MARYLAND 20902			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 5/12/1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION (CITY OR TOWN) FALLS CHURCH, VIRGINIA	
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REG'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Body released by Dr. May

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 2 1 3 2 6 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
BLANKA					5/14/82				
3. SEX female					2b. HOUR 10 30 A M				
4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR				
					6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN) Germany					7b. CITIZEN OF WHAT COUNTRY? U. S. A.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					12b. KIND OF BUSINESS OR INDUSTRY				
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13b. STREET ADDRESS 6721 Montrose Road				
14. FATHER'S NAME FIRST MIDDLE LAST Samson Michaelis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Berliner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 577-44-2255				
17. INFORMANT 822 S. W. 81st Street Philipp Goldmann Miami, Florida 33157									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Fibrillation									
DUE TO, OR AS A CONSEQUENCE OF (c) Acute M-I.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21e. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that I (this hospital) attended the deceased from 5:11 PM, 19 82, to 5:11 PM, 19 82, that I (we) lost saw the deceased alive on 5:11 PM, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.									
22b. SIGNATURE H.D. Khoury					22c. DATE SIGNED 5/14/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.D. KHOURY					22e. ADDRESS Suburban Hosp. Bethesda.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 5/16/1982				
23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Pr. Geo., Maryland				
24. FUNERAL DIRECTOR Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.					25. DATE REC'D. BY REGISTRAR MAY 18 1982				

1000

1000

1000

1000

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "PRO" and "1000" are visible.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

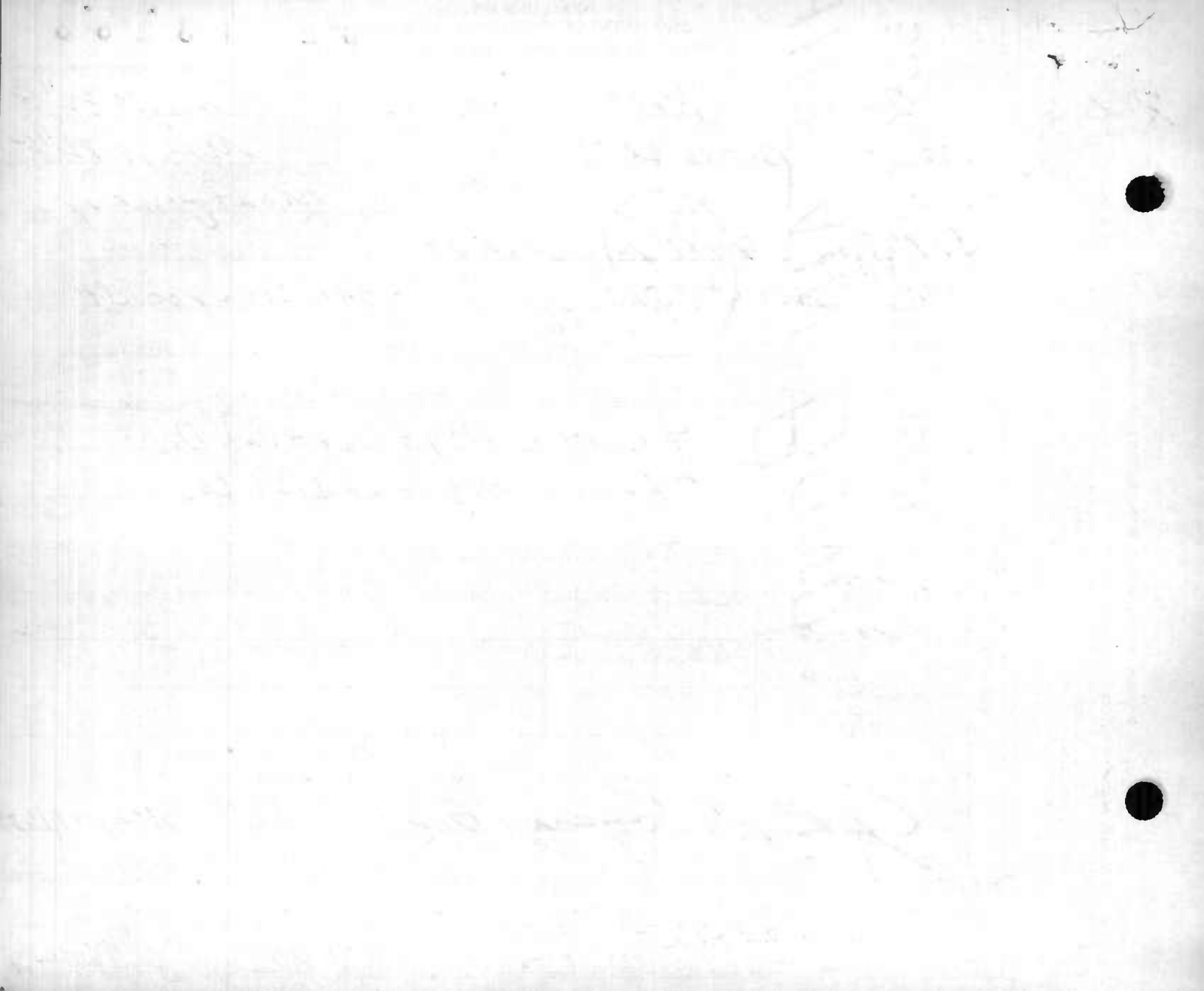
DHMH-17
(VRA15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Dwayne Keith Gooselaw</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>May 17 1982</i>			2b. HOUR OF DEATH M <i>11</i> A <i>23</i>		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 12 26 55</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>26</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>May 17 1982</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N. D.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Sil Spr</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9411 Monvoe St</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Contracting Officer</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD</i>		13b. CITY OR TOWN <i>Mont</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <i>9411 Monvoe St</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>George E. Gooselaw</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara T. Hansen</i>			16. ADDRESS <i>2308 Ross Road</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		(IF YES, GIVE WAR OR DATES) <i>WWII</i>		16b. SOCIAL SECURITY NO. <i>577-30-7581</i>		17. INFORMANT <i>Dolores Aker Sil. Spr., Md. 20910</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Chronic Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>								
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) <i>M.D.</i>			MEDICAL EXAMINER		DATE SIGNED <i>May 17 1982</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, DME</i>			ADDRESS <i>Silver Spring, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/20/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Howard E. Hale</i>				P.O. Box 7428		25a. DATE REC'D. BY REGISTRAR <i>MAY 24 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>
Warner E. Pumphrey, Inc., Sil. Spr., Md.								



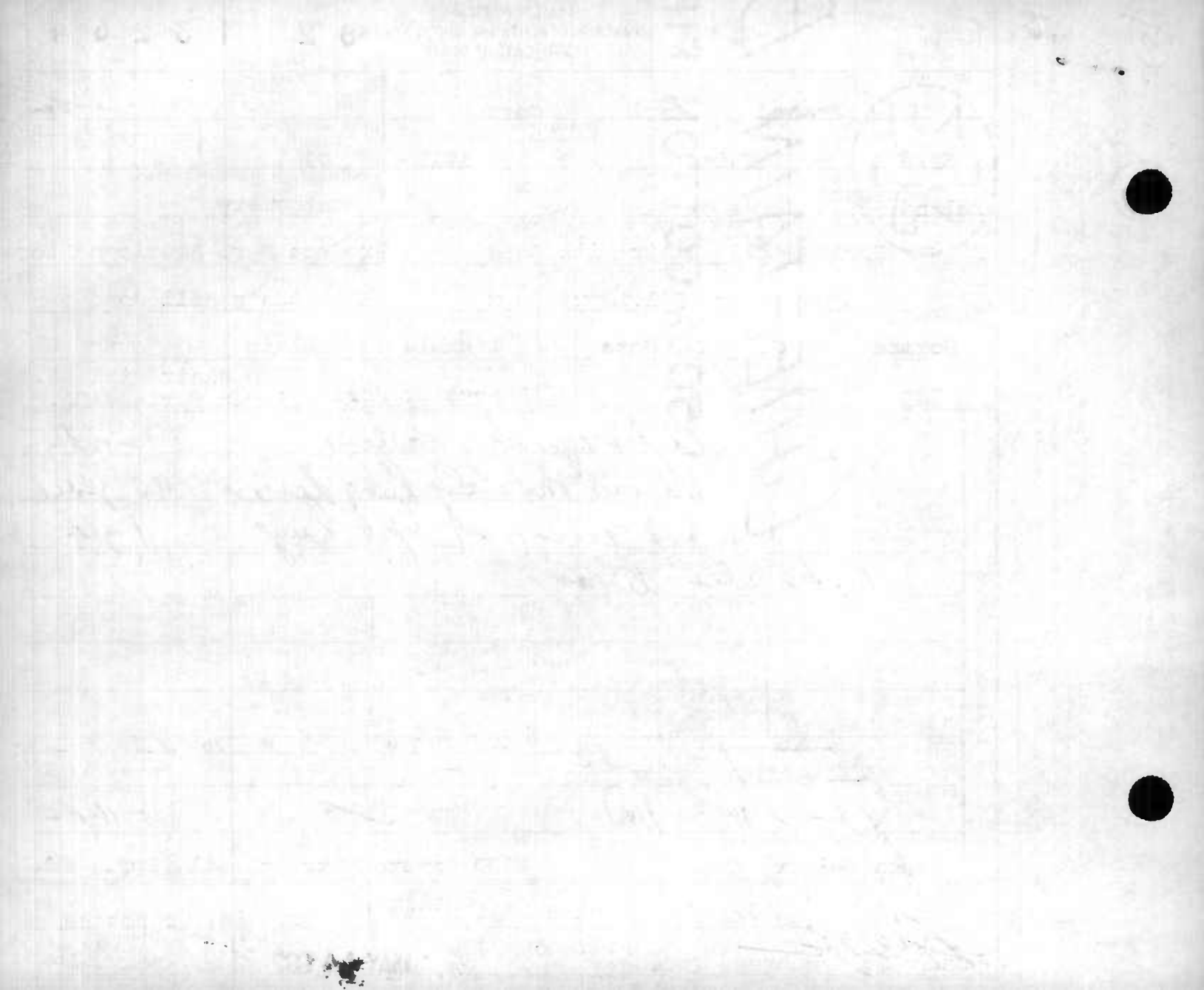
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 15 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 2 6 4					
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR					
FIRST MIDDLE LAST					MONTH DAY YEAR					MONTH DAY YEAR					
Ermond Carl Goss					5 10 82					8:10 am					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		3 17 1911		71 YRS		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Tennessee Island #35		U. S. A.				Montgomery MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		1220 Blair Mill Road								Produce Mgr. American Store		Co.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.				Montgomery		Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1220 Blair Mill Road					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Horace G. Goss				Mable Clair Wever											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes				WW II		413-14-9025		Fannye D. Goss		1220 Blair Mill Rd. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure</i>										1 month					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive lung disease</i>										10 years					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>and carcinoma of right lung</i>										1 year					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Peptic ulcer disease</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
22. I certify that (1) (the hospital) attended the deceased from <i>6-25 1976</i> to <i>5-10 1977</i> , that (1) (we) last saw the deceased alive on <i>5-10 1977</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.															
22a. SIGNATURE				DEGREE				22c. DATE SIGNED							
<i>Jason Geiger, M.D.</i>								5-11-82							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
Jason Geiger, M. D.				8830 Cameron Street, Sil. Spr., Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial				5/13/82		Forest Hill Cemetery		CITY OR TOWN COUNTY STATE							
								Memphis, Tennessee							
24. FUNERAL DIRECTOR				P.O. Box 7428				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.				Sil. Spr., Md.				MAY 14 1982		<i>Frances Jean Nathan</i>					

BP

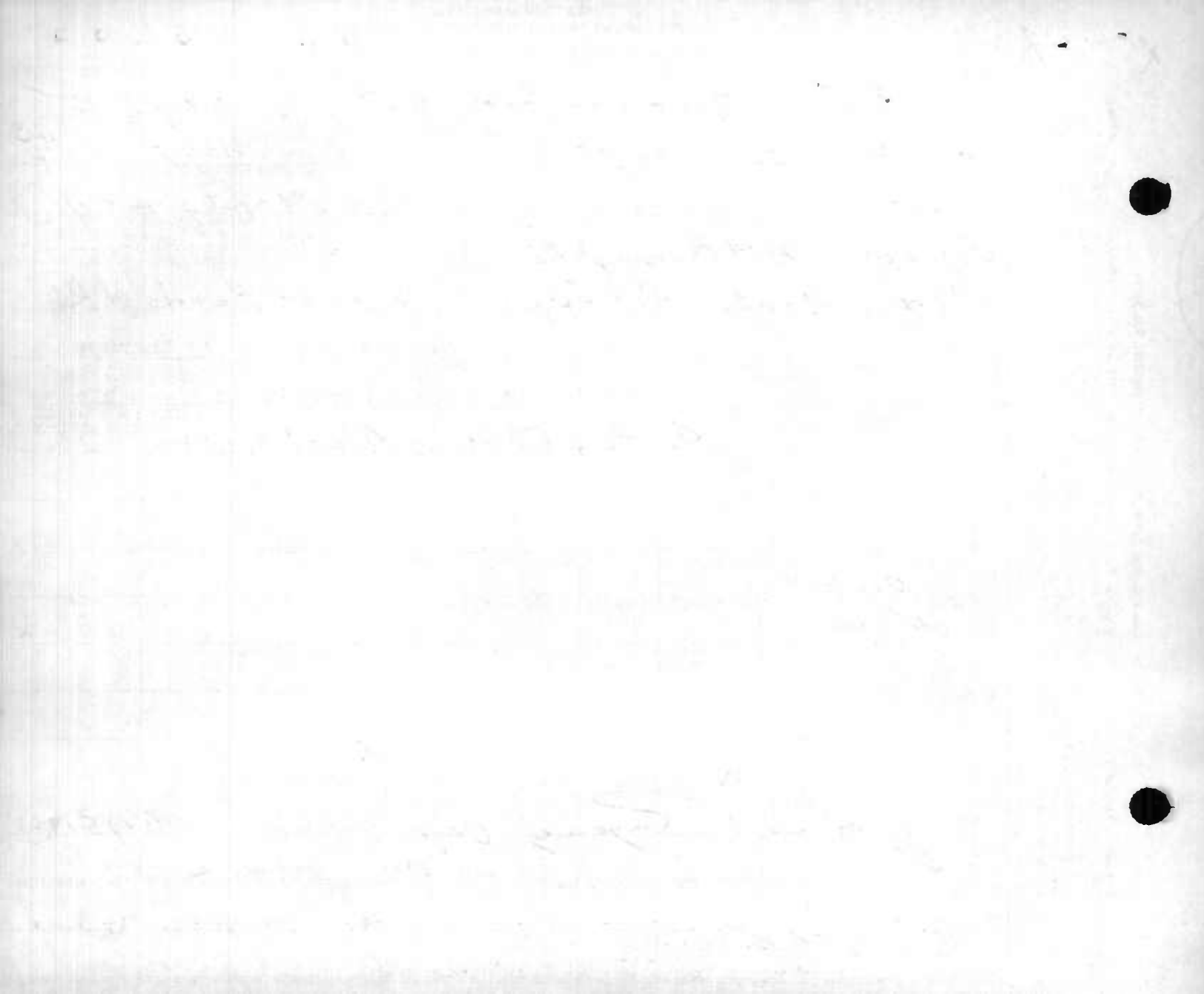


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHM-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13265	
1. DECEASED NAME (TYPE OR PRINT) Emily Taliauna Greenblatt										20. DATE KNOWN OF DEATH May 1 1982	
3. SEX F	4. RACE W	5. DATE OF BIRTH June 26 57	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD May 5 1982		24. HOUR 4:45 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Sil. Spr.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2104 Randolph Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hospital Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE MD		13b. COUNTY Montg		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2104 Randolph Rd			
14. FATHER'S NAME FIRST MIDDLE LAST John Oleson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. Unobtainable		17. INFORMANT ADDRESS Ruth M. Greenblatt		26241 Lake-Shore Blvd. Euclid, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Alcoholism 3130 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										PROXIMATE INTERVAL BETWEEN DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. diabetes											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers M.D.				TITLE (SPECIFY) Dep. MEDICAL EXAMINER				DATE SIGNED May 5 1982			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers DME				ADDRESS Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria		COUNTY Virginia		STATE	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS				P.O. Box 7428 Sil. Spr., Md.		25a. DATE REC'D BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 2 6 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE A. GREENE			2a. DATE OF DEATH MONTH DAY YEAR 5 9 82		2b. HOUR 2:00 AM		
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN 24, 1896		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1804 FLORIN STREET		13f. ZIP CODE 20902		14. FATHER'S NAME FIRST MIDDLE LAST JAMES HELLEMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BARRETT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT EDWARD J. GREENE, JR.		18. ADDRESS SAME AS 13 SON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE STROKE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 HRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) ADVANCED AGE; SEIZURE DISORDER							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 60 to MAY 9 19 82 , that (I) (we) last saw the deceased alive on MAY 8 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard T. Delaney, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD T. DELANEY, MD		22e. ADDRESS 4323 HAVARD ST SILVER SPRING 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LACKAWANNA ERIE NEW YORK	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			
26. ADDRESS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the attending physician. The law requires that the death certificate be executed with the attending physician. The law requires that the death certificate be executed with the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medicare claimant must be notified of the event.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 2 6 7

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harry FULLER GREENMAN.</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>5-1-82</i>		2b. HOUR <i>11:39</i> AM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 23, 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ill.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montg.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Electrical Engineer.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Navy</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <i>Maryland. Takoma Park.</i>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <i>603 Ethan Allen Ave. Tak.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Don Alvarez Greenman.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sophia Eberhardt Burdette.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN, YES, GIVE WAR OR DATES) <i>Yes. W. W. #1</i>		16b. SOCIAL SECURITY NO. <i>216-44-1486</i>		17. INFORMANT ADDRESS <i>Beatrice S. Greenman. Wife 13 e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Histiocytic Lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4/12/82</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/1/82</i> to <i>5/1/82</i> , that (I) (we) last saw the deceased alive on <i>5/1/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>David Crommel</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/2/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation.</i>		23b. DATE <i>May 3, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bladensburg Rd. P. G. Md.</i>	
24. FUNERAL DIRECTOR <i>Funeral Home.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 7 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>			

Christion. May 2, 1982 Mt. Lincoln
Lincolnshire Rd. P. O. Box
Lincolnshire, Ill. 60466

Yos. W. W. 41 216-44-1486 Beatrice S. Greenman. Wife is a
Don Alvirer Greenman. Thomas Edward Burdette.

Harvard. name. Thomas Park. + 603 Ethan Allen Ave. Tam.
Thomas Park. Washington Advantiss Hosp. Electrical Engineer. Law.
U. S. A. +
White 1000. 25, 1892 86
Tempt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers; Pages 1 and 2 should be filed within 24 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 427-2733.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTIN CLAY GROSS			2a. DATE OF DEATH MONTH DAY YEAR MAY 19 1982		2b. HOUR 0445a M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR DEC 12 40		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER		12b. KIND OF BUSINESS OR INDUSTRY USMC
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE VIRGINIA	13c. CITY OR TOWN PRINCE WM.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4018-B LYMAN PARK		
14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE C. GROSS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE LEOTA SIMPSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1958-1982	17. INFORMANT ADDRESS QUANTICO, VA		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOMA w/PULMONARY AND RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2028 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 14 MAY 82 to 19 MAY 82 , that (I) (we) last saw the deceased alive on 19 MAY 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>K.M.H. Lee</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 19MAY82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.M.H. LEE, LT, MC, USNR		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May. 24, 1982	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Nancy, Pulaski, Kentucky
24. FUNERAL DIRECTOR NAME ADDRESS W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg.		25a. DATE REC'D. BY REGISTRAR MAY 24 1982	25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>

0 0 0 0 1 0 0

NOTED 12/20/01

MAILED 12/20/01

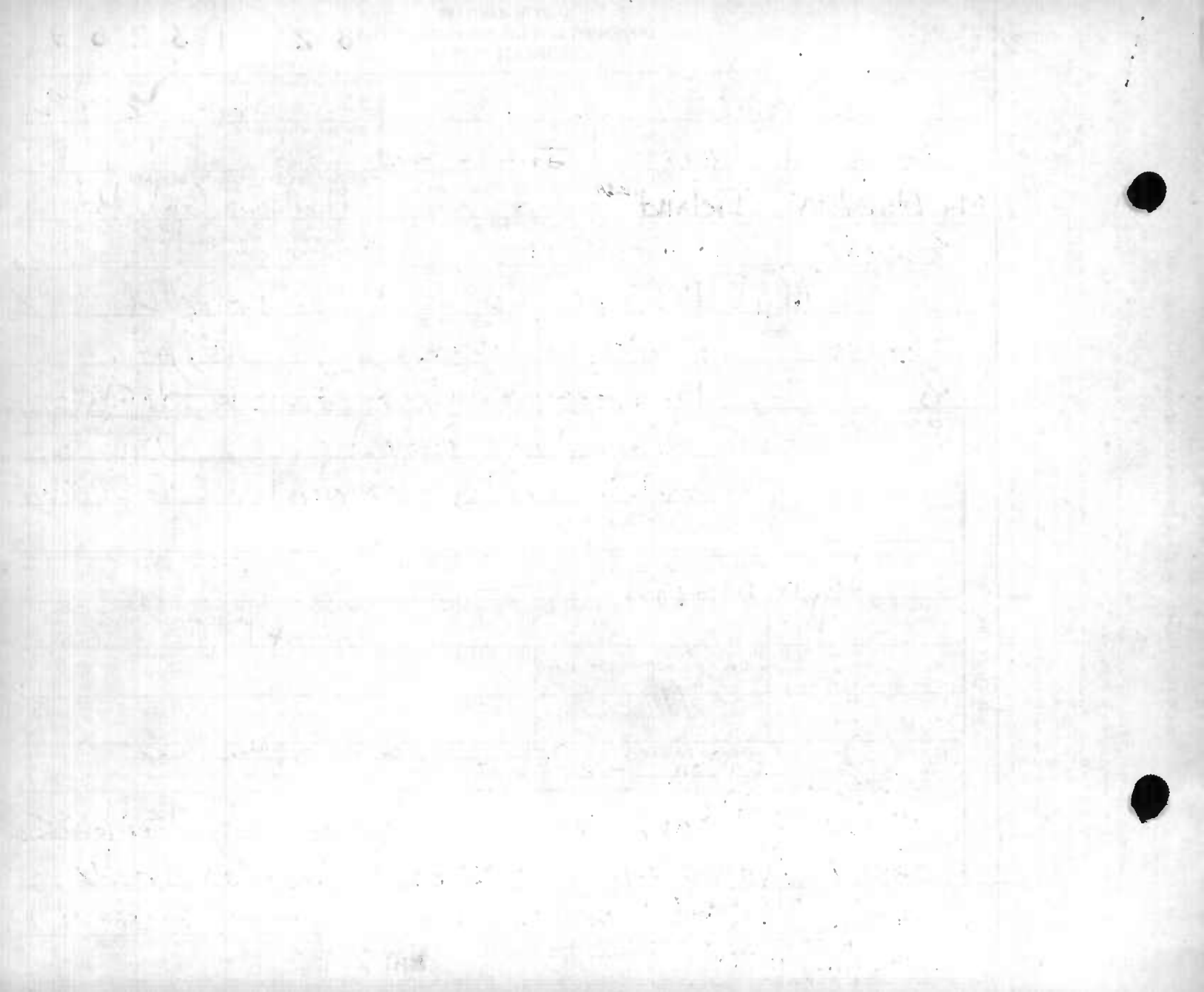


MAILED 12/20/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 1 3 2 6 9	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Katherine Goulian		May 5 82		9:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	Jan 16 1896	86 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Ireland	United States	Montgomery County, Md.		Homemaker	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
Potomac	8626 Bunnell Drive	Home		8626 Bunnell Dr.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	14. FATHER'S NAME	
Md	Mont	Potomac	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Thomas Dooley	
15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
McNally		546-02-3340		Kathleen Kalish (Daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION	
(a) IMMEDIATE CAUSE (a) Respiratory Arrest		10 minutes		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
(b) Cerebrovascular Accidents		2 1/2 weeks		20a. AUTOPSY?	
(c) DUE TO, OR AS A CONSEQUENCE OF				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
Hypertension		YES <input type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY	
				HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (If this hospital) attended the deceased from		1972, to		5 May 1982, that (I) (we) lost	
saw the deceased alive on		3 May 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Paul J. Nones MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Paul J. Nones MD		500 E. Howard St. Baltimore, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY STATE	
Burial	11, 1982	Holy Sepulchre	Hayward, California		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		MAY 10 1982		[Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13270	
1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) Kenneth Meade Haley Sr.										20. DATE KNOWN OF DEATH May 14, 1982	
3. SEX Male										20. HOUR 930	
4. RACE White										20. MIN. 8	
5. DATE OF BIRTH Jan. 24, 1933										20. YEAR 1982	
6. AGE (IN YEARS) 49										20. MONTH 5	
7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.										20. DAY 14	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										20. HOUR 930	
7b. CITIZEN OF WHAT COUNTRY? USA										20. MIN. 8	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										20. YEAR 1982	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery										20. MONTH 5	
10. CITY OR TOWN OF DEATH Silver Spring										20. DAY 14	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11807 Idlewood Rd.										20. HOUR 930	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman										20. MIN. 8	
12b. KIND OF BUSINESS OR INDUSTRY Lumber										20. YEAR 1982	
13a. STATE MD										20. MONTH 5	
13b. COUNTY Mont										20. DAY 14	
13c. CITY OR TOWN Silver Spring										20. HOUR 930	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20. MIN. 8	
13e. STREET ADDRESS 11807 Idlewood Rd.										20. YEAR 1982	
14. FATHER'S NAME (FIRST MIDDLE LAST) Arthur Meade Haley										20. MONTH 5	
15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Violet Hiawatha Crown										20. DAY 14	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										20. HOUR 930	
16b. SOCIAL SECURITY NO. 578-40-5089										20. MIN. 8	
17. INFORMANT ADDRESS Nancy Lee Haley same as 13e										20. YEAR 1982	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4291 (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None											
19a. DATE OF OPERATION None										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John S. Rogers M.D. Dep. MEDICAL EXAMINER										DATE SIGNED May 13, 1982	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers ADDRESS Old Seminary Road Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 5/18/82	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park										23d. LOCATION CITY OR TOWN Rockville COUNTY Maryland STATE	
24. FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Md. 20852										25a. DATE REC'D. BY REGISTRAR MAY 10 1982	
25b. REGISTRAR'S SIGNATURE [Signature]											

50% COTTON FIBRE



100% COTTON



No. 100-1000 Nanyang No. 100-1000

100% COTTON

100% COTTON

100% COTTON 100% COTTON 100% COTTON 100% COTTON 100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 2 7 1							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Millard Hall						2a. DATE OF DEATH MONTH DAY YEAR May 26, 1982		2b. HOUR A M 2:00 A	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 18, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS 58		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 405 Calvin Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Auto Supply	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 405 Calvin Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Millard Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcella Gluck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 218-12-4695		17. INFORMANT ADDRESS Opal C. Hall, Wife, Same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART ARRHYTHMIA 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 19 76 to 3 82, that (1) (we) last saw the deceased on 3 3 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) see the body after death.									
22b. SIGNATURE Joel L. Goozh M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel L. Goozh M.D.				22e. ADDRESS 4701 Randolph Rd. #105, Rockville, Md. 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Thane Jan. Nathan			

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										82-13272 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) William Charles Hall										2a. DATE KNOWN OF DEATH MONTH 5 DAY 28 YEAR 1982	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 29 YEAR 23		6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED MONTH 5 DAY 28 YEAR 1982		2b. HOUR 10:00 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12101 Whippoorwill Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Karl MIDDLE W. LAST Hall					15. MOTHER'S MAIDEN NAME FIRST Carol MIDDLE C. LAST Conklin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1973		17. INFORMANT Mary G. Hall, Same as #13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of The Lung 1629 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Chronic obstructive Pulmonary Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tamber				TITLE (SPECIFY) M.D.				DATE SIGNED 5-28-82			
EXAMINER'S NAME (TYPE OR PRINT) John Tamber				ADDRESS 8218 Wisconsin Ave				BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE James J. Hester			

BP

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

29-1-1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 7 3			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST AKA/Valentine Walter J. Hamernick				MONTH DAY YEAR May 9, 1982		240 2 PM M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		MONTH DAY YEAR Feb. 10, 1897		85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		United States				Montgomery County, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville		Potomac Valley Nursing Home				Electrical Line Foreman	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
PA.		North Mount		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		147 North Chestnut Street	
14. FATHER'S NAME FIRST MIDDLE LAST Simon Hammernick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Augustlyn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WWI				180 09 3333		Daniel J. Hamernick Son 1912 Henry Road Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sideroblastic anemia</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sideroblastic anemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>5-9</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>D. L. Bucy</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>5-9-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<u>D. L. Bucy</u>				<u>SN Jones 809 Veirs Mill Rd Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 12, 1982		St. Joseph's		Mount Carmel Township, PA	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				MAY 12 1982		<u>Frances J. Hadden</u>	

1881

May 1955



1881

May 1955

May 1955

May 1955



May 1955

May 1955



May 1955

May 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 1 3 2 7 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Lucy Brewer Hamilton		May 18, 1982		10:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	AUG 15, 1893	88	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
OLNEY	SHARON NURSING HOME	CLERK	H.E.W.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	8802 MANCHESTER ROAD 20901	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
JOHN BREWER		VIRGINIA RUSSELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		220-44-6409		VIRGINIA M. HAMILTON DAUGHTER SAME AS 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>4392</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCEVD</u>					<u>2 wk</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCEVD</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCEVD</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
<u>0 damage to lungs</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-24-14</u> , 19 <u>73</u> , to <u>5-18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>				<u>5/18/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>C.N. Ligon</u>		<u>1814 Pk Philip Dr</u>		<u>Olney MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		5/19/82		METROPOLITAN CREMATORY	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS		500 UNIVERSITY BOULEVARD WEST, SILVER SPRING, MD.		MAY 24 1982	
25b. REGISTRAR SIGNATURE					
<u>[Signature]</u>					

BP

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Remains may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 2 1 3 2 7 5					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Edmund Philip Hammett					5 15 1982 11 ⁵⁵ P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE		CAUCASIAN		APRIL 22, 1913		69 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.A.				MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING		HOLY CROSS HOSPITAL				ACCOUNTANT		PEPCO		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND					MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
BERNARD T. HAMMETT					MARGARET LYONS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES					WW II		577-05-0185 BERNICE K. HAMMETT SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) RECURRENT CARDIO-PULMONARY ARREST										
4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 HOURS 30 DAYS YEARS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/17/82, 1982, to 5/15, 1982, that (I) (we) lost saw the deceased alive on 5/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Harold W. Draper M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			5/16/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
HAROLD W. DRAPER M.D.					9801 GEORGIA AVE, SILVER SPRING MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL		5/19/82		GATE OF HEAVEN		SILVER SPRING MONT MD.				
24. FUNERAL DIRECTOR NAME					25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS					MAY 19 1982					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

MEDICAL CERTIFICATION

3 2 0

THE UNIVERSITY OF CHICAGO
LIBRARY

Chicago, Illinois
May 19, 1961

Dear Mr. [Name]
I have your letter of May 15, 1961, regarding the [Topic].
I am sorry that I cannot give you a more definite answer at this time.
The [Topic] is still under consideration and I will be in touch with you again as soon as a final decision has been reached.

Sincerely,
[Signature]
[Name]

Enclosed for you are two copies of the [Document].
I hope this information is helpful to you.

Very truly yours,
[Signature]
[Name]

May 19, 1961
[Name]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

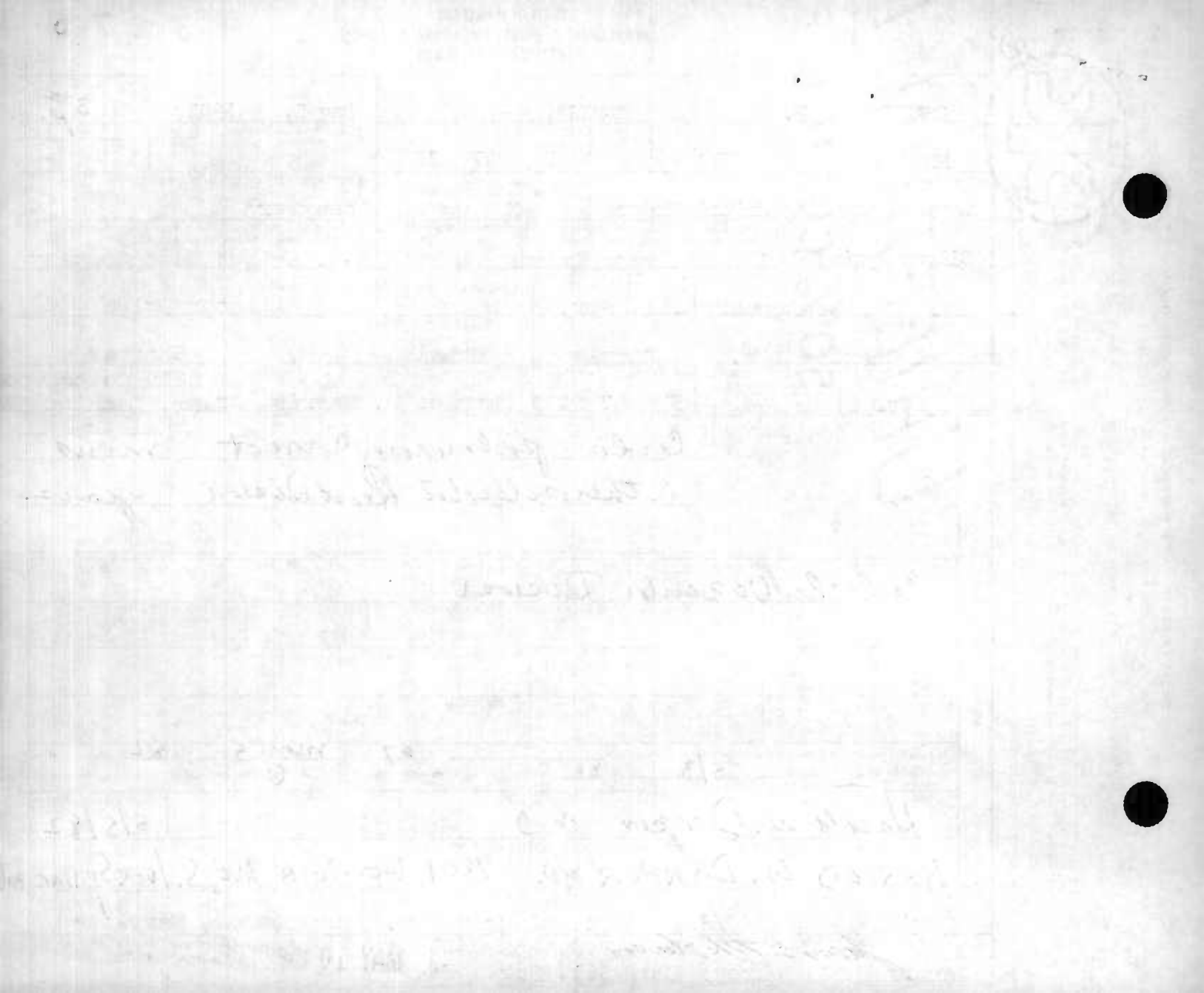
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLES W. HARRIS, Sr.			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1982			2b. HOUR 3⁰⁰ P. M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 27 15		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 3 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 400 Hillmoor Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Briggs Meat Company		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 Hillmoor Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie W. Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel M. Sharber		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II					
16b. SOCIAL SECURITY NO. 578-07-6773		17. INFORMANT ADDRESS 5219 Cottonwood Charles W. Harris, Jr. Dr. Lothian, Md							
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - pulmonary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Coronary Vascular Disease									
19a. DATE OF OPERATION 5/3/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 67 to May 5, 19 82 , that (I) (we) lost saw the deceased alive on 5/3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Harold W. Draper M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/5/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.		22e. ADDRESS 9801 GEORGIA AVE, SILVER SPRING MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc., Sil. Spr., Md.		P.O. Box 7428		25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 2 1 3 2 7 7				
1. DECEASED NAME (TYPE OR PRINT) Viola Clay Harris					2a. DATE OF DEATH MONTH DAY YEAR 5-16-82 12:40 PM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 11 1911		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST unknown Knighton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			13e. STREET ADDRESS 44 W. Deer Park Rd. Apt. #20			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 216-88-2879		17. INFORMANT ADDRESS H.F. Harris 3823 Brightview Ct. Wheaton, Md. 20902				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Probable acute MI DUE TO, OR AS A CONSEQUENCE OF (b) 1 Hour Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CVA - multiple									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 5/15/82 to 5/16/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) David Cromwell				22c. ADDRESS 831 University Blvd. E. Silver Spring, Md.				22e. DATE SIGNED 5/16/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/18/82		23c. NAME OF CEMETERY OR CREMATORY Wildwood Baptist Church Cemetery Bethesda, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAY 19 1982	
24. FUNERAL HOME, INC. Tyson Wheeler Funeral Home, Inc.					25a. REGISTRAR'S SIGNATURE [Signature]				
1331 Rockville Pike Rockville, Md. 20852									

1001	1002	1003	1004	1005	1006	1007	1008	1009	1010
1011	1012	1013	1014	1015	1016	1017	1018	1019	1020
1021	1022	1023	1024	1025	1026	1027	1028	1029	1030
1031	1032	1033	1034	1035	1036	1037	1038	1039	1040
1041	1042	1043	1044	1045	1046	1047	1048	1049	1050
1051	1052	1053	1054	1055	1056	1057	1058	1059	1060
1061	1062	1063	1064	1065	1066	1067	1068	1069	1070
1071	1072	1073	1074	1075	1076	1077	1078	1079	1080
1081	1082	1083	1084	1085	1086	1087	1088	1089	1090
1091	1092	1093	1094	1095	1096	1097	1098	1099	1100
1101	1102	1103	1104	1105	1106	1107	1108	1109	1110
1111	1112	1113	1114	1115	1116	1117	1118	1119	1120
1121	1122	1123	1124	1125	1126	1127	1128	1129	1130
1131	1132	1133	1134	1135	1136	1137	1138	1139	1140
1141	1142	1143	1144	1145	1146	1147	1148	1149	1150
1151	1152	1153	1154	1155	1156	1157	1158	1159	1160
1161	1162	1163	1164	1165	1166	1167	1168	1169	1170
1171	1172	1173	1174	1175	1176	1177	1178	1179	1180
1181	1182	1183	1184	1185	1186	1187	1188	1189	1190
1191	1192	1193	1194	1195	1196	1197	1198	1199	1200

1001 1002 1003 1004 1005 1006 1007 1008 1009 1010

1011 1012 1013 1014 1015 1016 1017 1018 1019 1020

1021 1022 1023 1024 1025 1026 1027 1028 1029 1030

1031 1032 1033 1034 1035 1036 1037 1038 1039 1040

1041 1042 1043 1044 1045 1046 1047 1048 1049 1050

1051 1052 1053 1054 1055 1056 1057 1058 1059 1060

1061 1062 1063 1064 1065 1066 1067 1068 1069 1070

1071 1072 1073 1074 1075 1076 1077 1078 1079 1080

1081 1082 1083 1084 1085 1086 1087 1088 1089 1090

1091 1092 1093 1094 1095 1096 1097 1098 1099 1100

1101 1102 1103 1104 1105 1106 1107 1108 1109 1110

1111 1112 1113 1114 1115 1116 1117 1118 1119 1120

1121 1122 1123 1124 1125 1126 1127 1128 1129 1130

1131 1132 1133 1134 1135 1136 1137 1138 1139 1140

1141 1142 1143 1144 1145 1146 1147 1148 1149 1150

1151 1152 1153 1154 1155 1156 1157 1158 1159 1160

1161 1162 1163 1164 1165 1166 1167 1168 1169 1170

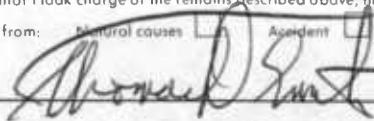
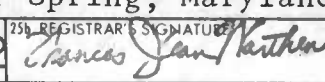
1171 1172 1173 1174 1175 1176 1177 1178 1179 1180

1181 1182 1183 1184 1185 1186 1187 1188 1189 1190

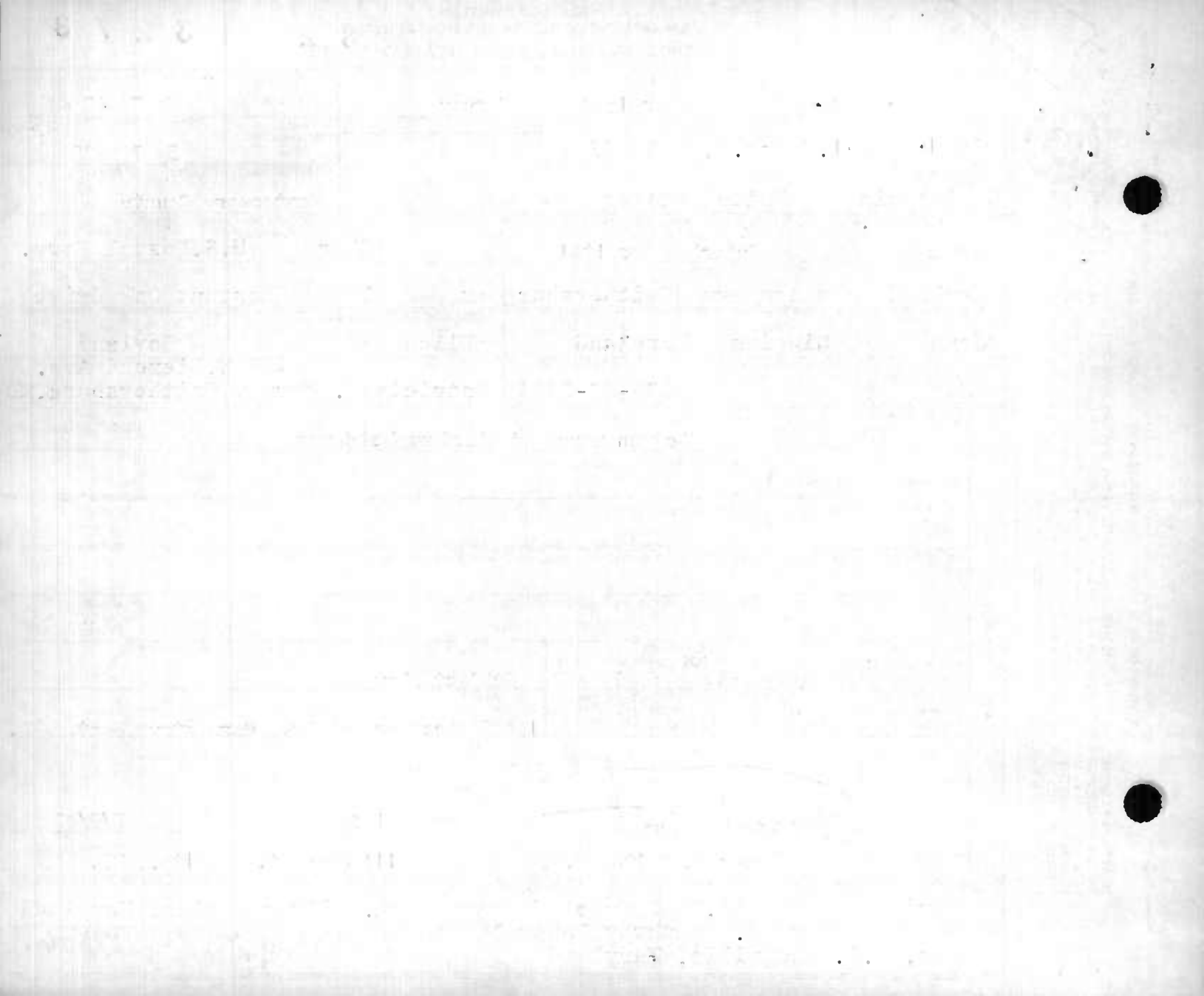
1191 1192 1193 1194 1195 1196 1197 1198 1199 1200

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13278	
1. DECEASED NAME (TYPE OR PRINT) Jean Moreland Harvey						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 7 1982			2b. HOUR M		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1926		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 55		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 7 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Serv.		
13a. STATE Maryland						13b. CITY OR TOWN Montgomery Gaithersburg		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 13009 Chestnut Oak Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John Higgins Moreland						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Boyland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 573-32-7524		17. INFORMANT Patricia E. Harvey, Gaithersburg, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of chest and abdomen DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 8:30 P.M. MONTH DAY YEAR 5 7 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13009 Chestnut Oak Dr., Darnestown, Mont. MD.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 5/8/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION



O.K. by Dr. Rogers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR Mary S. Hassler					REG. NO. 7213279				
1 DECEASED NAME (TYPE OR PRINT) MARY S. HASSLER					2a. DATE OF DEATH MONTH May DAY 5 YEAR 82 2b. HOUR 8:46 AM				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 9 DAY 8 YEAR 48		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY US Treasury	
13a. STATE D.C.		13b. COUNTY None		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4916 - 43 Pl. N.W.	
14. FATHER'S NAME FIRST William F. MIDDLE Hassler LAST Hassler					15. MOTHER'S MAIDEN NAME FIRST Katie MIDDLE A. LAST Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-60-0648		17. INFORMANT ADDRESS 212 Sandalwood Rd. Rt. # 17 Carol Garrison Millville, N.J. 08332					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary edema 440 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure 1 year. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerotic Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) 24 hours 1 year									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from June , 19 80 , to May 5 , 19 82 , that (I) (we) last saw the deceased alive on 5-5-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P. P. Andrews DEGREE					22c. DATE SIGNED 5-5-81			22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. P. ANDREWS	
22e. ADDRESS 4977 BATTERY LA. BETHESDA MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Md. COUNTY STATE			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.					25a. DATE REC'D. BY REGISTRAR MAY 7 1982 25b. REGISTRAR'S SIGNATURE James Van Nostrand				

Coroner's report

P. P. Andrews

P. P. Andrews

2-20-81

777 BATTERY LA BARRA

Coroner's report
and autopsy
of the body of
John William
Henderson

John William Henderson
born 1871
died 1881
cause of death
drowning

John William Henderson
born 1871
died 1881
cause of death
drowning

Page 2 of 2

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lisa Elaine Hayner		7a. DATE KNOWN OF DEATH ESTIMATED May 19, 1982		7b. HOUR 2:50	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Nov 22 61	6. AGE IN YEARS (LAST BIRTHDAY) 20 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Burtonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3930 Blackburn Rd Apt 12		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
13a. STATE MD		13b. CITY OR TOWN Mont Burtonsville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Norman Haynes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Crabtree		17. INFORMANT ADDRESS 6509 20th. Ave	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-76-0605		17. INFORMANT ADDRESS Norman Haynes-father-Hyatts., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 955-4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:00 A.M. 5 12 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot self	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Blackburn Rd. Burtonsville Mont MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep		DATE SIGNED May 20, 1982	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1919 Seminary Rd., S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-21-82		23c. NAME OF CEMETERY OR CREMATORY George Washington	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR MAY 27 1982	
		25b. REGISTRAR'S SIGNATURE James J. Thibault			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

CS. Govt.

Class

Grades

8209 2000, 40

11-1-7-5025 Forman Warren-La-Har-Harcel, 40

John F. Johnson, 11-1-7-5025 Forman Warren-La-Har-Harcel, 40

11-1-7-5025 Forman Warren-La-Har-Harcel, 40

MAY 1950

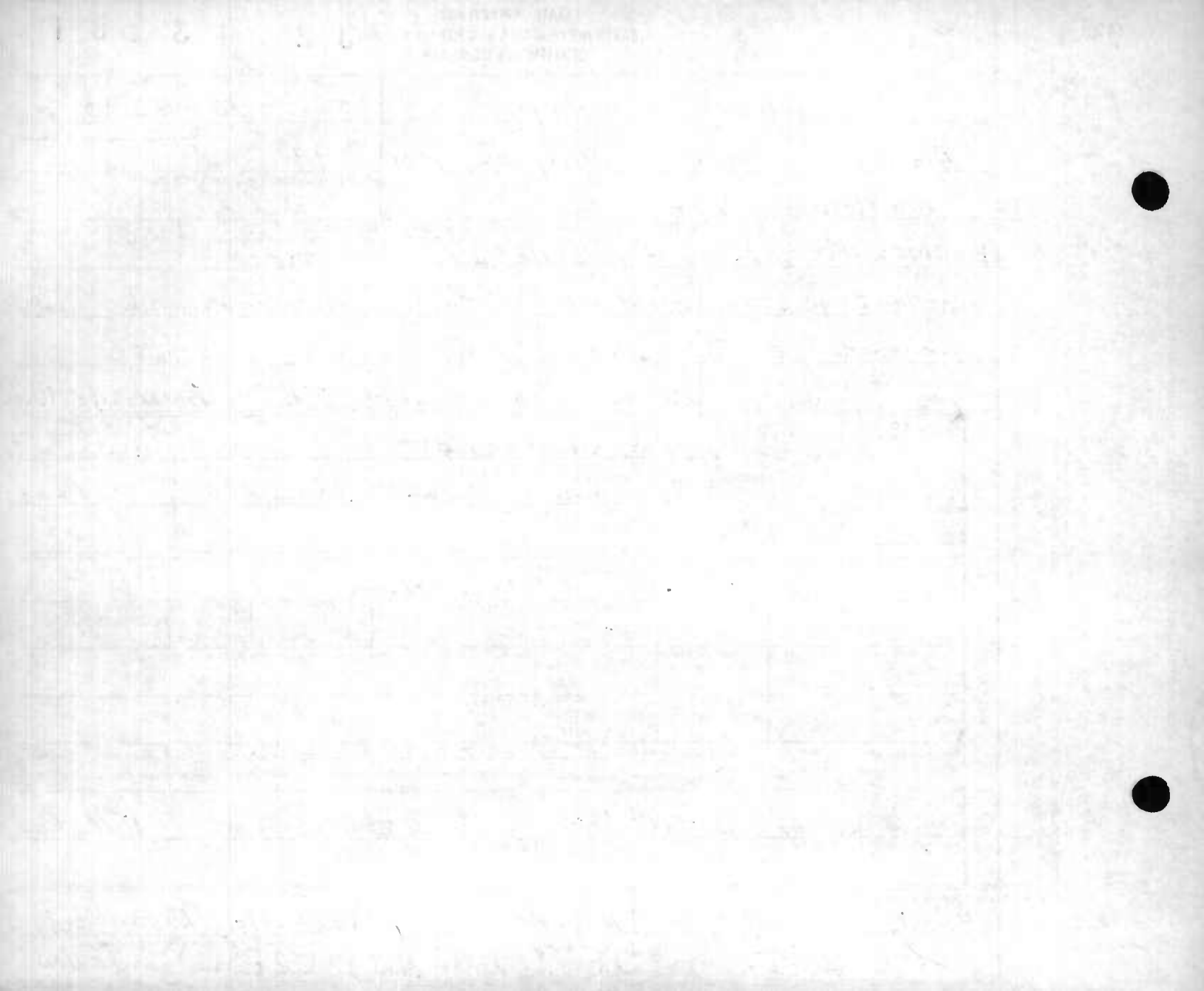
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post mortem retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
7 2 1 3 2 8 1										
1. FOR STATE REGISTRAR										
REG. NO.										
1 DECEASED NAME (TYPE OR PRINT) LEONARD					2a. DATE OF DEATH MONTH 5 DAY 10 YEAR 82					2b. HOUR 2 P.M.
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH Aug DAY 28 YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.				
10. CITY OR TOWN OF DEATH BARNESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18120 BARNESVILLE Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN BARNESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18120 BARNESVILLE Rd.		
14. FATHER'S NAME FIRST Leonard MIDDLE I. J. LAST HAYS					15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE E. W. LAST WHITE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT Mrs Elizabeth Tolbert		ADDRESS BARNESVILLE Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Wearing Rosemaker										
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY STATE 		
22a. I certify that (I) (this hospital) attended the deceased from Feb 27, 19 82 to May 3, 19 82 , that (I) (we) last saw the deceased alive on May 3, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE John J. Fawcett					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/10/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Fawcett					22e. ADDRESS 					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/82		23c. NAME OF CEMETERY OR CREMATORY Monkney		23d. LOCATION CITY OR TOWN Beallsville COUNTY Montg. STATE Md.				
24. FUNERAL DIRECTOR NAME W.C. Hill ADDRESS Barnesville Rd.					25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. Anthony			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 1 3 2 8 2	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MARY MIDDLE EILEEN LAST HEIKEN		MONTH 05 DAY 28 YEAR 82		1019 AM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 10 DAY 21 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Rockville		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY Mont.		13. CITY OR TOWN Silver Spring		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
15. STREET ADDRESS 15211 Elkridge Way		16. MOTHER'S MAIDEN NAME Mary Flanigan		17. ADDRESS SAME #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOVASCULAR SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURE SIGMOID COLON		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden SIX DAYS SIX DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CORONARY ART. DISEASE, MYOCARDIAL INFARCTION, ATRIAL FIB.					
19a. DATE OF OPERATION 5-23-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURE SIGMOID COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9-14-78, 1982, to 5-28-82, that (1) (we) last saw the deceased alive on 5-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Earl Vivino, M.D.		DEGREE M.D.		22c. DATE SIGNED 5-28-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. EARL VIVINO, M.D.		22e. ADDRESS 4801 URBANA PIKE FREDERICK, MD 21707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JUNE 1, 1982		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland		23e. NAME OF D. BY REGISTRAR JUN 3 1982			
24. FUNERAL DIRECTOR NAME John F. DeLoe ADDRESS DE VOL FUNERAL HOME WASH. D.C.					

1 3 3 3

Mary Ellen Barker

in 17 17

THIRD

THIRTY

MARYLAND MOUNTAIN X Silver Spring

JAMES

KEANE

MARY

FLANIGAN

INDIVIDUAL C. Barker

NO

CARROLL ARREST

CARROLL ARREST

CARROLL ARREST

2 21 42



2-28-82

A BORN 1/10/10

But in 1 June 1982

2-21 General News

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			8 2 1 3 2 8 3 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) KATE			FIRST NM			MIDDLE Heimowitz			LAST		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH Dec. DAY 12, YEAR 1899			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Romania			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE New York			13b. CITY OR TOWN Bronx			13c. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>			13d. STREET ADDRESS 2922 Barnes Avenue		
14. FATHER'S NAME FIRST Benjamin MIDDLE Felder LAST Rose			15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE Kotrusser LAST Kotrusser			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 091-22-8188		
17. INFORMANT Dorothy Engel			18. ADDRESS 12639 Georgia Avenue			19. CITY OR TOWN Silver Spring			20. STATE MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular tachycardia DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease 4149										APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH 2 min 1/2 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes, Hypertension, Pulmonary embolism, Arterial embolism											
19a. DATE OF OPERATION April 20, 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small intestinal obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, YARD, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from April 14 1982 to May 12 1982 that (i) (we) last saw the deceased alive on May 11 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. S. Bresler MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED May 12, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur S. Bresler, M. D.			22e. ADDRESS 10881 Lockwood Drive			Silver Spring, MD 20901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 16, 1982			23c. NAME OF CEMETERY OR CREMATORY Baron Hirsch Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Staten Island, New York		
24. FUNERAL DIRECTOR NAME Ives Funeral Home ADDRESS 2847 Wilson Blvd., Arlington, VA 22201			25. DATE REC'D BY REGISTRAR MAY 17 1982			25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH : 16-25M

(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 2 8 4

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROSA M. HELLER			2a. DATE OF DEATH MONTH DAY YEAR MAY 1 1982			2b. HOUR 5:20 AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Takoma Park		13d. STREET ADDRESS 1004 Hopewell Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown. Alpeter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.			
17. INFORMANT Henry A. Heller (Son)			18. SOCIAL SECURITY NO. 13 8 9			19. ADDRESS 13 8 9			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Metastatic carcinoma of bladder 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic organic brain syndrome									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Jan 1 , 19 81 , to May 1 , 19 82 , that (1) (we) last saw the deceased alive on 4/21 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22b. SIGNATURE Martin C. Shargel			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL			22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD - 20895						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.			23b. DATE May 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln.		23d. LOCATION Bladensburg Rd. P. G. STATE Md.		
24. FUNERAL DIRECTOR (NAME) Robert Keller			25. ADDRESS Takoma Funeral Home. 254 Carroll St. N. W. D.			26. DATE REC'D. BY REGISTRAR MAY 7 1982		27. REGISTRAR'S SIGNATURE James J. G. Miller	

1331

Montgomery

Montgomery

Takoma Park

1004 Homewood Ave.

Unknown

Albany

Unknown

Henry A. Miller (Son) 1331

THE
NEW
COLLEGE



Washington D.C. 20004

Washington D.C. 20004

Takoma Park, Maryland

1004 Homewood Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 8 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Anne E. Hesterberg				2a. DATE OF DEATH MONTH DAY YEAR May 17, 1982		2b. HOUR 9:30 AM	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec 28, 1911		6. AGE [IN YEARS (LAST BIRTHDAY)] 70 YRS.	
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9009 Wooden Bridge Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Schmidt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Leiding			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577 70 1779		17. INFORMANT Gregory C. Hesterberg		ADDRESS see # 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>squamous cell</u> (c) <u>due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/18/82</u> , 19 <u>82</u> , to <u>4/14</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Victor M. Perigo, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 17, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Perigo, M.D.				22e. ADDRESS 3800 Reservoir Rd., NW. Washington, D.C. 20007			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20 1982		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE MAY 24 1982			

BP

66-61-28

10

NOV 10 1966

11/10/66

NOV 10 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marde L. Hildt			2a. DATE OF DEATH MONTH DAY YEAR 5/25/82			2b. HOUR 425 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 8th 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE STREET ADDRESS) Bethesda Health Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Home	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS 2806 Glavin Way					
19. FATHER'S NAME FIRST Unknown LAST				20. MOTHER'S MAIDEN NAME FIRST Lutita MIDDLE Heath LAST					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO		22. SOCIAL SECURITY NO. 215 50 3224		23. INFORMANT NAME Earl H. Hildt ADDRESS (Same AS #13)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiac arrest**
DUE TO, OR AS A CONSEQUENCE OF,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) **cachexia**
DUE TO, OR AS A CONSEQUENCE OF
(c) **Parkinson's Disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

immediate
1 day - standing
10 day - standing

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from Sept 31 , 19 81 , to May 25 , 19 82 , that (b) (we) lost the deceased alive on May 21 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.							
22b. SIGNATURE Dr. Paul Kretzing				DEGREE M.D.		22c. DATE SIGNED 5/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul Kretzing				22e. ADDRESS 1811 Prince Philip Rd. Olney, Md 20832			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 28, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Silver Spring Md. ADDRESS				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

2/25/11 491

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999

1999



1999

1999

1999

1999

1999

1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 2 8 7							
1. DECEASED NAME (TYPE OR PRINT) George F. Hodge				2a. DATE OF DEATH MONTH DAY YEAR May 26, 1982		2b. HOUR 12:28p M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME William Henry Hodge				15. MOTHER'S MAIDEN NAME Elizabeth Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-30-5753		17. INFORMANT ADDRESS Melba J. Hodge, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordice Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 12 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atrial Fibrillation, Mitral Insufficiency, Congestive Heart Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (was hospital) attended the deceased from 5, 1970, to DATE, that (I) (was) last saw the deceased alive on 5-6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alan M. Weintraub M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan M. Weintraub, M.D.				22e. ADDRESS 5530 Wisconsin Ave. Chevy Chase, MD 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Geneva, New York			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Renee Jan North			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page 4 must be attached.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 1 3 2 8 8									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
NEWTON D. HOPTON								May, 26, 1982		839A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS. HOURS MIN	
Male		White		Nov. 28, 1910		71					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
California		US				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital						Shipping Business		Cargo	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md;		Montgomery		Bethesda				6204 Dahlonga Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Newton D. Hopton				Minerva Daly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW II-Korea		565-10-4593		Mark Hopton		Same as Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										<u>1/2 hr.</u>	
4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrest</u>										<u>1/2 hr.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral Heart disease</u>										<u>1 yr.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mell. tun.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29/71</u> , 19 <u>82</u> , to <u>5/26</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
<u>[Signature]</u>								<u>5/26/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
S. A. Thomas, M.D.						4301 - 48th St. N. W. Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		5/27/82		Cedar Hill Crematory		Suitland, Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. 20016						JUN 2 1982		<u>[Signature]</u>			

... ..

... ..

JUN 5 1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

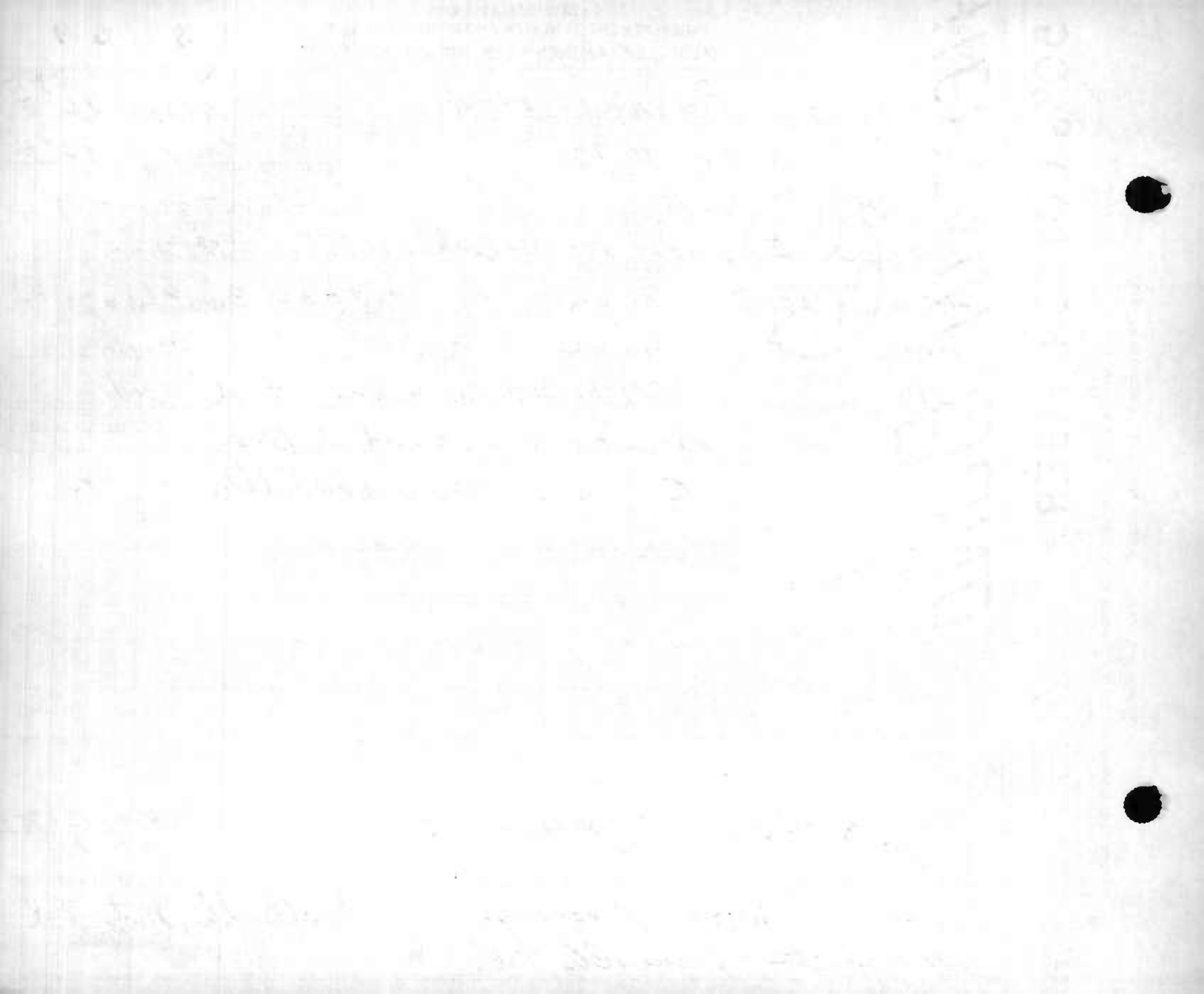
DMMH - 17
(VR 15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13289

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Douglas Edwin Horine			2a. DATE KNOWN OF DEATH ESTIMATED MAY 13 1982			2b. HOUR 5:25 PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Nov. 21 11 20 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) 61	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MAY 13 1982	2d. HOUR 5:25 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Boyd		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Enwoods at Old Buck Lodge Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm		12b. KIND OF BUSINESS OR INDUSTRY State Worker	
13a. STATE MD	13b. COUNTY Mont	13c. CITY OR TOWN Boyd	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 20301 Buck Lodge Rd				
14. FATHER'S NAME FIRST MIDDLE LAST John P Horine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Douglas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-32-2041		17. INFORMANT ADDRESS Mrs. Horne Boyd MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4yo								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED MAY 13 1982		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Mont Md.		
24. FUNERAL DIRECTOR NAME M. C. Kelt		ADDRESS Bernardsville Rd.		25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified if alive.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 2 9 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.			
FIRST MIDDLE LAST <i>Donald S. HOWARD</i>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>MAY 16 1982 1357 M</i>			
3. SEX <i>M ALE</i>		4. RACE <i>W HITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>FEB 02 07 11</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>71</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>	
10. CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SHADY GROVE ADVENTIST HOSP.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Contractor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Bldg.</i>	
13a. STATE <i>MD</i>				13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>GAITHERSBURG</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Linwood - Howard</i>				15. MOTHER'S MAIDEN NAME <i>Annie - Small</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>				16b. SOCIAL SECURITY NO. <i>578-10-5987</i>		17. INFORMANT ADDRESS <i>Lucille N. Howard Same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>monoclonal gammopathy</i> 2731 DUE TO, OR AS A CONSEQUENCE OF (b) <i>lym</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COPD</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>5/16/82</i> to <i>5/16/82</i> , that (I) (we) last saw the deceased alive on <i>5/16/82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Greger</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/16/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Greger</i>		22e. ADDRESS <i>12105 Oakview Rd Gaithersburg Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>MAY 19, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION CITY <i>Rockville Mont. Md.</i>	
24. FUNERAL DIRECTOR <i>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 20 1982</i>		25b. REGISTRAR SIGNATURE <i>Francis H. Barber</i>	

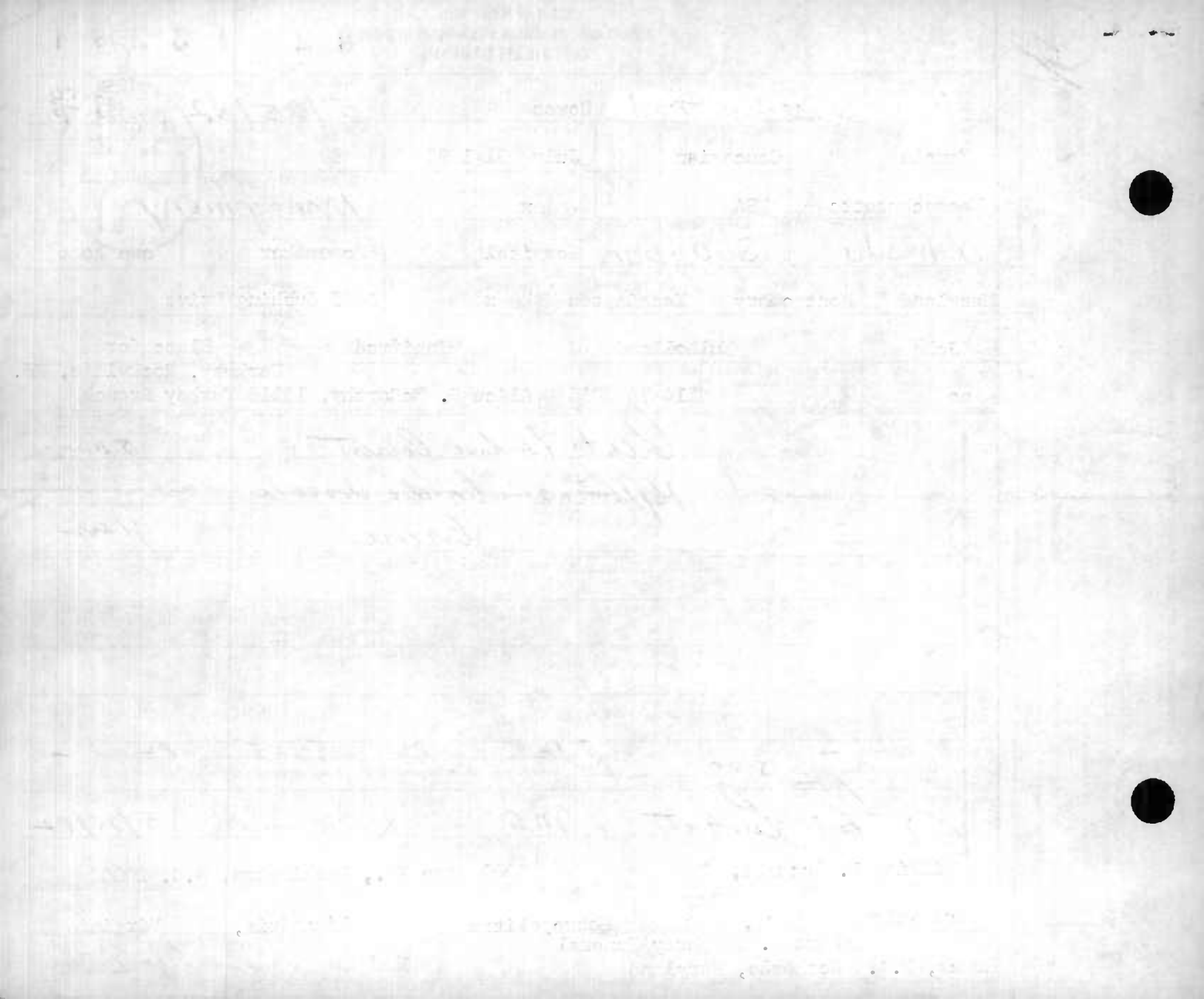
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 2 9 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Winnifred (nmi) Howes				2a. DATE OF DEATH MONTH DAY YEAR 5/25/82		2b. HOUR 2:30 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 31 1892		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Mulholland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winnifred Blatchford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214 74 0035		17. INFORMANT Alice S. McCarthy, 13118 Turkey Branch Parkway, Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Cardiac Arrest 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Stroke DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 7 hrs						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5-12 , 19 82 , to 5-25 , 19 82 , that (I) (we) last saw the deceased alive on 5-25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE William F. Luckett				DEGREE MD		27c. DATE SIGNED 5/25/82	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Luckett, MD				27e. ADDRESS 5000 Reno Rd., Washington, D.C. 20008			
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Cremation		23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 27 1982			
				25b. REGISTRAR'S SIGNATURE Anna J. [Signature]			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE WESLEY HUGUELY, JR.			2a. DATE OF DEATH MONTH DAY YEAR May 10 - 1982		2b. HOUR 9³⁵ A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 26, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA 5215 Cedar Ln.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Investor		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Huguely		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel R. Shepherd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT George W. Huguely, III - Bethesda, Md. 20814		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 3320 DUE TO, OR AS A CONSEQUENCE OF (b) Parkinsons Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years " "						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Gastric intestinal Bleeding						
19a. DATE OF OPERATION April 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TUR for Prostatic Obstruction		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
22a. I certify that (I) James W. Egan attended the deceased from May 9, 1982 , to May 10, 1982 , that we (we) lost saw the deceased alive on May 9, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) did (did) view the body after death.		22b. SIGNATURE James W. Egan MD		22c. DATE SIGNED 5-10-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN		22e. ADDRESS 5413 Cedar Ln. - Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-12-82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem'l. Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland						
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. - Washington, D.C.				25a. DATE REC'D. BY REGISTRAR MAY 14 1982		
25b. REGISTRAR'S SIGNATURE James W. Egan						

1 3 1 3 1 3

1942

... ..
... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked "other," it shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Mayle, Deputy Med. Exam., notified & approved.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Edward T. Hutchison, Jr.		May 20 1982		6 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Nov. 22, 1918		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS.	
Virginia		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Potomac		11109 Hunt Club Drive		Vice Pres.		Office Supplies			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Potomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11109 Hunt Club Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Edward T. Hutchison, Sr.		Elsie Conti		No		579-12-6686		Helen L. Hutchison, Same address as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac ARREST</u>		(b) <u>ARTERIOSCLEROTIC Cardiovascular disease</u>		(c) <u>moments years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4292		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 24</u> 19 <u>76</u> to <u>May 20</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>April 6</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>De Witt E. De Lawter</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>May 20, 82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
De Witt E. De Lawter		6318 Democracy Blvd., Bethesda, Md.		Burial		5/24/82		Parklawn Cemetery	
23d. LOCATION (CITY OR TOWN COUNTY STATE)		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR	
Rockville, Maryland		MAY 26 1982		<u>Joseph Gawler's Sons, Inc.</u>		5130 Wisconsin Ave., NW, Wash., D.C. 20016			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 2 9 4 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nina L'meta Hyberg						2a. DATE OF DEATH MONTH DAY YEAR 5-6-82				2b. HOUR 4 A.M.			
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 10 7 13		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 68				IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4509 Woodfield Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4509 Woodfield Road					
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Johnston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Van Raden									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-56-9983		17. INFORMANT ADDRESS Mr. George R. Hyberg 4509 Woodfield Road Kensington, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 yrs 30 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1979 , 19____, to 5-6-82 , 19____, that (I) (we) last saw the deceased alive on 5-4-82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jeremy V. Cooke MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-6-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke						22e. ADDRESS 10400 Conn. Ave. Kensington							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 5/6/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												
FOR 1 - STATE REGISTRAR					7a. DATE OF DEATH MONTH DAY YEAR					7b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy M. Hysan</i>					7a. DATE OF DEATH MONTH DAY YEAR <i>5 13 82</i>					7b. HOUR <i>12 26</i> M		
1. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-10-20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.		8. UNDER 1 YEAR MONTHS DAYS		9. UNDER 60 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.						
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
13a. USUAL RESIDENCE (IF HUSBAND, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13c. STREET ADDRESS <i>11607 - Idlewood Rd.</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Robert B. Milton</i>					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Corrinne M. Parker</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-18-8519</i>		17. INFORMANT ADDRESS <i>John H. Hysan - above address</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency (Husband)</i> <i>3320</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Aspiration pneumonia (or failure)</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Severe Parkinson disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Unable to swallow; chronic renal disease</i>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>03/26/82</i> P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)				
22a. I certify that (I) (this hospital) attended the deceased from <i>03/26/82</i> 19____ to <i>05/13/82</i> 19____, that (I) (we) last saw the deceased alive on <i>5/13/82</i> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Miguel A. Rodriguez</i> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/13/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <i>831 Univ. Blvd. S.S. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5/17/1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>			23d. LOCATION (CITY OR TOWN COUNTY STATE) <i>Brentwood Pr. Gop. Md.</i>				
24. FUNERAL DIRECTOR NAME <i>Valley's F.H. Inc.</i> ADDRESS <i>Mt. Rainier, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 18 1982</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



8/1/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 2 1 3 2 9 6				
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
CLARENCE MICHAEL ISRAEL					MAY 07 1982				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		CAUCASIAN		OCT 20 1950		31		5:52a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
NORTH CAROLINA		UNITED STATES				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NATIONAL NAVAL MEDICAL CENTER				COMMUNICATIONS		U. S. NAVY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		PRINCEGEORG		ANDREWS, AFB		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4654-2 CHICAGO DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
CLARENCE WILLIAM ISRAEL				ALMA ELIZABETH WOODY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES		1969-1982		246-76-7902 CLARENCE W. ISRAEL ROUTE 1, BOX 446 PISGAH FOREST, NC 28768					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST-ATRIAL SEPTAL DEFECT</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACCOMPANIED BY BIVENTRICULAR FAILURE AND PULMONARY HYPERTENSION</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>02 MAY</u> 19 <u>82</u> , to <u>07 MAY</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>07 MAY</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) not want him/her after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<i>Richard W. Foley</i>					MD			7 MAY 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
RICHARD W. FOLEY, M.D., MC, USNR					NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			5-11-1982		Boylston Church Cem.		Hy. 80 Henderson, N.C.		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.W. Chambers Co, 8655 Georgia Ave, Sil. Spg.					MAY 12 1982		<i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

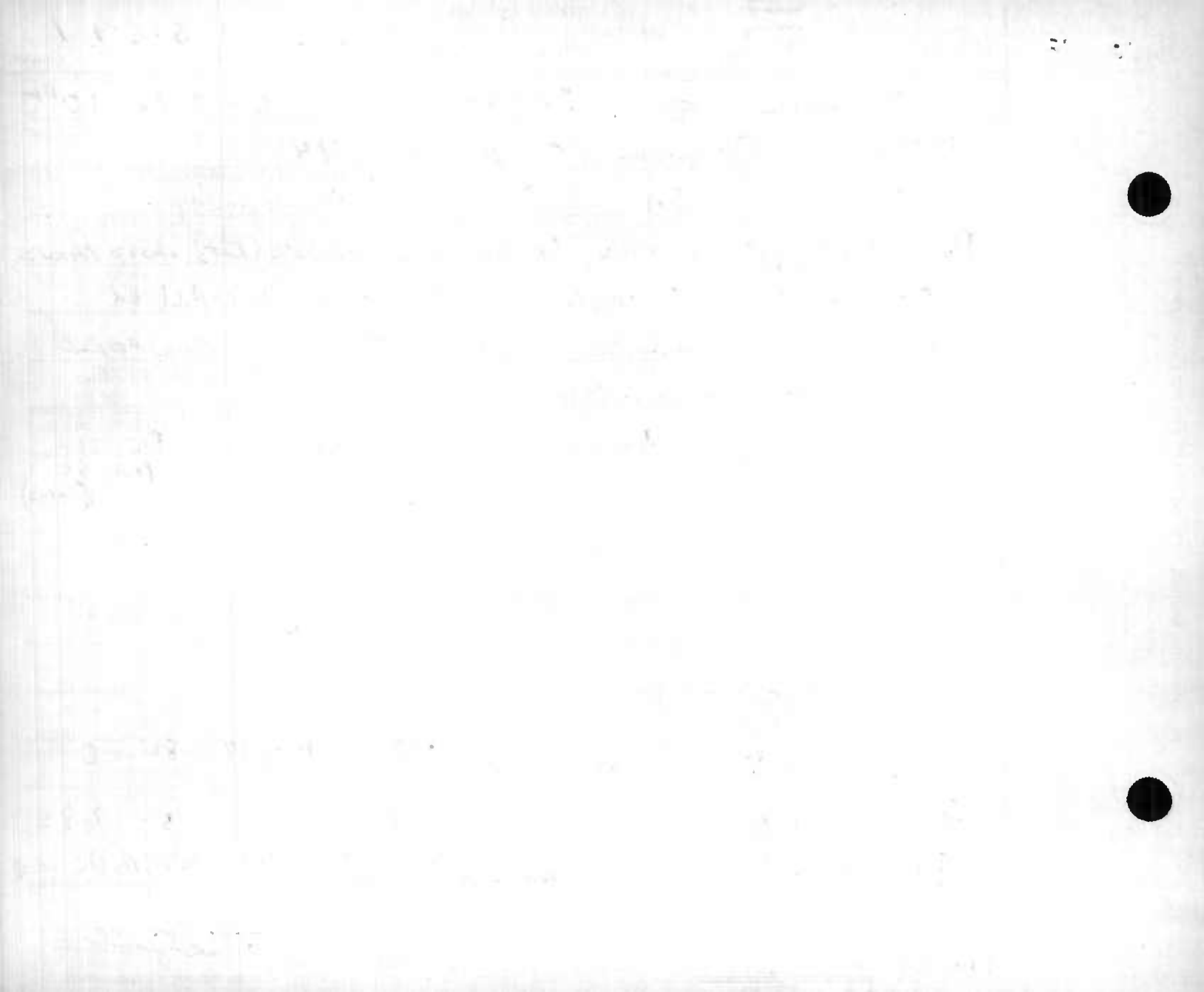
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 2 9 7					
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MELVILLE			MIDDLE G.			LAST JACOBS			2a. DATE OF DEATH MONTH DAY YEAR 5-17-82		2b. HOUR 10 PM	
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR 8 5 07			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH POTOMAC, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER (RET.)		12b. KIND OF BUSINESS OR INDUSTRY AUTO PARTS	
13a. STATE MD			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5225 Pooks Hill Rd				
14. FATHER'S NAME FIRST MIDDLE LAST DAVID JACOBS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANNIE SANFORD			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -						16b. SOCIAL SECURITY NO. 219-01-5729			
17. INFORMANT Tessie M. Jacobs			ADDRESS Bethesda, Md. 5225 Pooks Hill Road												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1919 BRAIN Tumor - GLIOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DEC '81 - MAY '82 (same)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 79 to May 17, 19 82, that (I) (we) last saw the deceased alive on 4-28-19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Francis Chucker MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-17-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS CHUCKER MD			22e. ADDRESS 2700 CALVERT ST NW, WASH DC 20008												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-19-1982			23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, Md						
24. FUNERAL DIRECTOR NAME DANZANSKY - GOLDBERG			ADDRESS ROCKVILLE PA			25a. DATE REC'D. BY REGISTRAR MAY 24 1982			25b. REGISTRAR'S SIGNATURE [Signature]						

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					7 2 1 3 2 9 8 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH MONTH DAY YEAR					
Dorothy Mae Jacobson					May 19, 1982					
3 SEX					2b HOUR					
Female					8:17a M					
4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
White		June 1, 1895			86 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Massachusetts		U.S.A.				Montgomery County MD.				
10. CITY OR TOWN OF DEATH		11: NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring		801 Dale Drive			Editor			U.S. Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		801 Dale Drive		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Fred Daniels					Mary E. Fowler					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No					None		216-44-3448 Roy Charles Jacobson/Husband/Same as # 13.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) metastatic carcinoma of bladder DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1; OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from June 19, 1981 to May 19, 1982, that (I) (we) last saw the deceased alive on April 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Dr. Frederick Frensilli					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			May 19, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Dr. Frederick Frensilli, M.D.					5530 Wisconsin Ave. Suite 901 Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation			May/20/82		Cedar Hill Crematory		Suitland, P.G. Co., Maryland			
24 FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. GIST OF INQUIRY			
Chambers Funeral Home Silver Spring, Maryland					MAY 24 1982					



100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 2 9 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
Frank Y. JAGGERS, Sr.				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FRANK Y. JAGGERS		MAY 13 '82		9:45 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE	White	Aug. 15, 1889		92 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.	U.S.A.			Montgomery MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Rockville Nursing Home, Inc.		Minister		United Meth. Church		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	303 Adclare Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Benjamin --- JAGGERS		Catherine --- LOUNSBURY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		217-32-4828		11017 Rosemont Drive Frank Y. JAGGERS, Jr. - Rockville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY DONE IN 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY 1st HOME, STREET, FACTORY, OFFICE, FARM, ETC.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from _____ 1978 to _____ 1982 saw the deceased alive on _____ 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body attend to it.)		22b. SIGNATURE Thos G. WARD, M.D.		22c. ADDRESS 6116 ROBIN WOOD, Bethesda, MD 20817		22d. DATE SIGNED 5/14/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 17, 1982		Parklawn Mem'l. Park		Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Avenue, N.W.-Washington, D.C.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				MAY 18 1982		James J. Thacker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner/make notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 3 3 0 0			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
Mildred C. Jardin				May 23, 1982		8:00AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		April 15, 1938		44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Indonesia		United States				Montgomery County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		Artist		Interior Design	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14013 Bethpage Lane	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Hendrik W. Engelen				Georgine Tambajong			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				100-38-7528		Robert P. Jardin, Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>dysmatured varicella</u>							
0520 DUE TO, OR AS A CONSEQUENCE OF:							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF _____							
(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
<u>probable dysmatured intravascular coagulation</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
—		—		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 19 <u>79</u> , to <u>MAY 23</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>Elliot R. Goldstein</u>				MD		5/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Elliot R. Goldstein, M.D.				9410 Old Georgetown Road Bethesda, Maryland 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 26, 1982		Gate of Heaven Cemetery, Silver Spring, MD.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				JUN 1 1982		<u>Theresa J. Heston</u>	

BP

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13301	
1. DECEASED NAME (TYPE OR PRINT) DENZIL S. JENKINS							2a. DATE KNOWN OF DEATH May 20, 1982		2b. DATE OF DEATH May 20, 1982		
3. SEX Male	4. RACE white	5. DATE OF BIRTH July 14, 1936	6. AGE (IN YEARS) 45 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD May 20, 1982	7d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto Leasing			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sprng		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3933 Wendy Lane			
14. FATHER'S NAME Fred			15. MOTHER'S MAIDEN NAME Mina			16. ADDRESS Cantwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT Penelope A. Jenkins-wife (sm. as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 5 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 5:20 PM 5/20/82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CHEST PAIN AT WORK					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) WORK			21f. LOCATION 10330 SOUTHARD RD BELTSVILLE P.G. MD			21g. CITY OR TOWN BELTSVILLE P.G. MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Francis C. Mayle			TITLE (SPECIFY) Dyt			MEDICAL EXAMINER			DATE SIGNED 5/20/82		
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle			ADDRESS 820 Wisconsin Ave Bethesda MD			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-25-1982		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave S.S. Md.			23c. NAME OF CEMETERY OR CREMATORY McFarland Cemetery			23d. LOCATION CITY OR TOWN McFarland		
25a. DATE REC'D. BY REGISTRAR MAY 27 1982			25b. REGISTRAR'S SIGNATURE James J. Hines								

100-100000

May 22 1961

STATION

2

REPORT

100-100000

May 14 1961

USA

USA

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

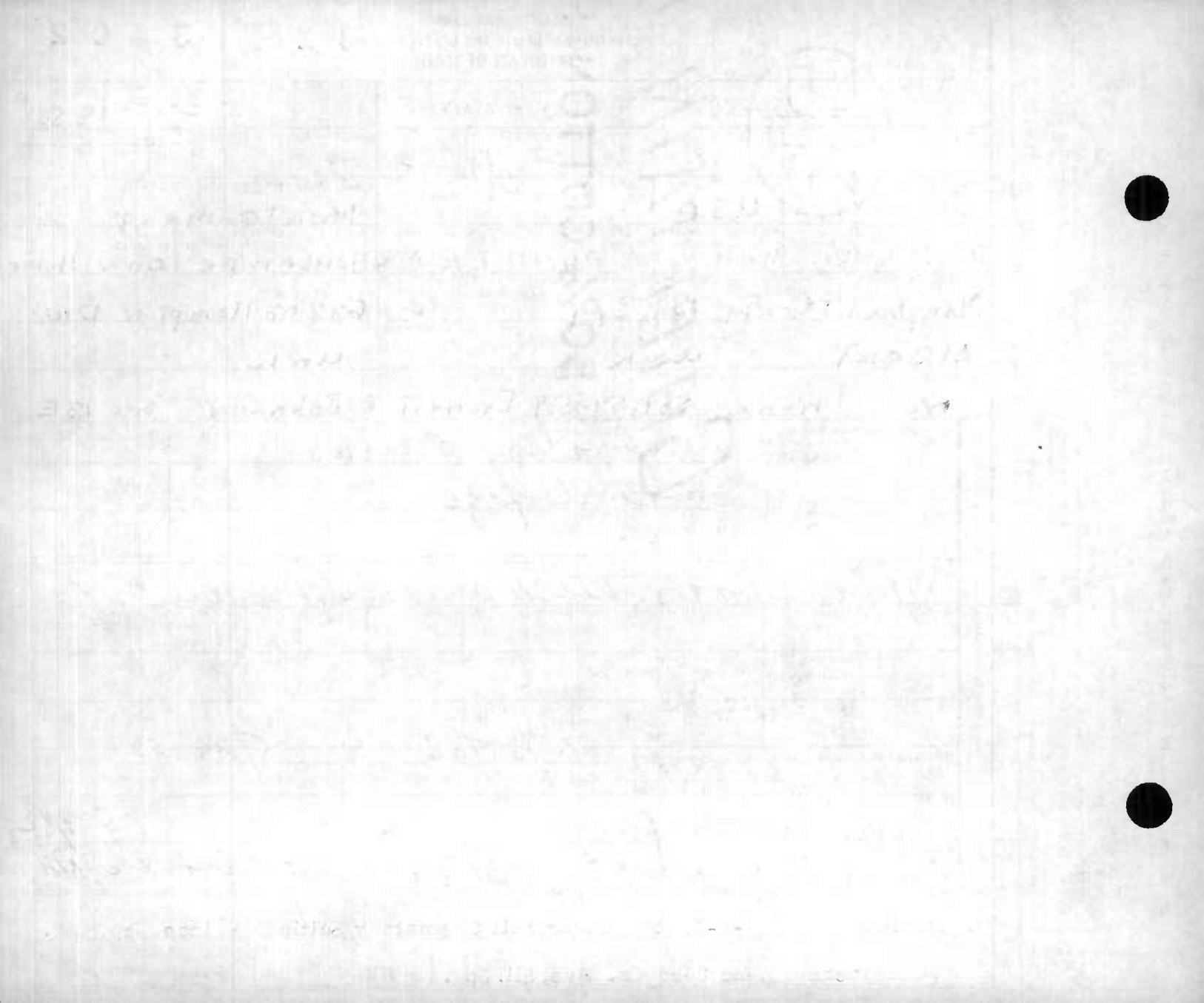
MAY 22 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

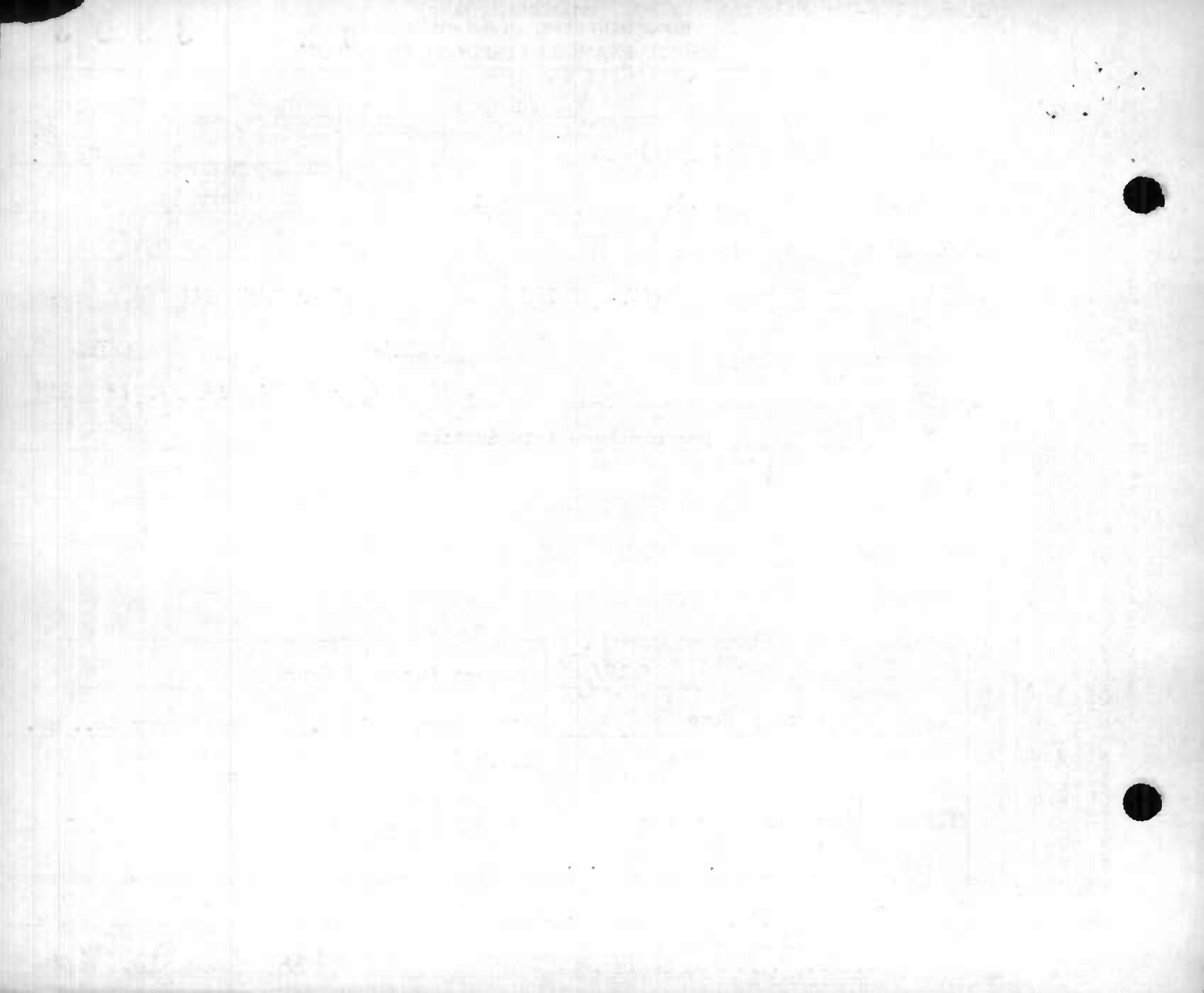
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 3 3 0 2	
1 - FOR STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDEGARD JOHNSON						2a. DATE OF DEATH MONTH DAY YEAR 5.28.82		2b. HOUR MIN. 8:55 P			
3 SEX F		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 19 18		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TK. PK. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montg Sil. Spg						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 622 No. Hampton Dr			
14 FATHER'S NAME FIRST MIDDLE LAST ALBERT UNK		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Ernest S. Johnson		See 13E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Brain damage. (c) CVA. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic heart disease, Previous CVA.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 05/28/82 to 05/28/82 , that (I) (we) lost saw the deceased alive on 05/28/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Miguel A. Rodriguez				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 05/29/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel A. Rodriguez				22e. ADDRESS 831 University Blvd. S.S. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-1-1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Prince Geo. Md.					
24 FUNERAL DIRECTOR NAME W. W. Chambers Co, Inc				ADDRESS 8655 Ga. Ave, Sil. Spg.		25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE [Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13303	
1. DECEASED NAME (TYPE OR PRINT) Zella Johnson										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY YEAR 5 17 1982	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 15 1915	6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 17 1982		2d. HOUR 2:05 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN-SUCH FACILITY, GIVE STREET ADDRESS) 510 Hexton Hill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 510 HEXTON HILL ROAD 20904	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
NO				NONE				WALLACE L. JOHNSON SAME AS 13 SON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. NONE	
17. INFORMANT ZELLA CATES										ADDRESS SAME AS 13 SON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9800 IMMEDIATE CAUSE (a) Propoxyphene intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/17/1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject ingested drugs			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 510 Hexton Hill Rd. Montgomery Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-18-82			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/20/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE Charles J. Van Natten			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 3 0 4

1. DECEASED NAME (TYPE OR PRINT) LOUISE C. KAHLE			2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982		2b. HOUR 11:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1894		
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5215 Cedar Ln.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Army Wife		12b. KIND OF BUSINESS OR INDUSTRY Home		13. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
13a. STATE ---		13b. CITY OR TOWN Washington, DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Ramsey Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary --- Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		
16b. SOCIAL SECURITY NO. 578-54-4955D		17. INFORMANT Mary K. Jordan		ADDRESS 5110 Westport Road Chevy Chase, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic cerebrovascular disease (c) Generalized arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wtc. 2 yr. 5 yr.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) atrial fibrillation, L. hip fracture 1982						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 6/16 , 19 78 , to 5/9 , 19 82 , that (I) (we) last saw the deceased alive on 5/9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Thomas L. Hartman M.D.		DEGREE M.D.		22c. DATE SIGNED 5/10/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Hartman, M.D.		22e. ADDRESS 3301 New Mexico Ave., N.W.-Washington, D.C.		22f. ADDRESS 3301 New Mexico Ave., N.W.-Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/82		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia		23e. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia		23f. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS Jos. Gawler's Sons, Inc. 5130 Wisc.Ave., N.W.-Washington, D.C.		25a. DATE REC'D. BY REGISTRAR MAY 14 1982		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

U.S. DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D.C. 20315
MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]
11. [Illegible]
12. [Illegible]
13. [Illegible]
14. [Illegible]
15. [Illegible]
16. [Illegible]
17. [Illegible]
18. [Illegible]
19. [Illegible]
20. [Illegible]
21. [Illegible]
22. [Illegible]
23. [Illegible]
24. [Illegible]
25. [Illegible]
26. [Illegible]
27. [Illegible]
28. [Illegible]
29. [Illegible]
30. [Illegible]
31. [Illegible]
32. [Illegible]
33. [Illegible]
34. [Illegible]
35. [Illegible]
36. [Illegible]
37. [Illegible]
38. [Illegible]
39. [Illegible]
40. [Illegible]
41. [Illegible]
42. [Illegible]
43. [Illegible]
44. [Illegible]
45. [Illegible]
46. [Illegible]
47. [Illegible]
48. [Illegible]
49. [Illegible]
50. [Illegible]
51. [Illegible]
52. [Illegible]
53. [Illegible]
54. [Illegible]
55. [Illegible]
56. [Illegible]
57. [Illegible]
58. [Illegible]
59. [Illegible]
60. [Illegible]
61. [Illegible]
62. [Illegible]
63. [Illegible]
64. [Illegible]
65. [Illegible]
66. [Illegible]
67. [Illegible]
68. [Illegible]
69. [Illegible]
70. [Illegible]
71. [Illegible]
72. [Illegible]
73. [Illegible]
74. [Illegible]
75. [Illegible]
76. [Illegible]
77. [Illegible]
78. [Illegible]
79. [Illegible]
80. [Illegible]
81. [Illegible]
82. [Illegible]
83. [Illegible]
84. [Illegible]
85. [Illegible]
86. [Illegible]
87. [Illegible]
88. [Illegible]
89. [Illegible]
90. [Illegible]
91. [Illegible]
92. [Illegible]
93. [Illegible]
94. [Illegible]
95. [Illegible]
96. [Illegible]
97. [Illegible]
98. [Illegible]
99. [Illegible]
100. [Illegible]

70
M.L. White MD
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
covering Ray Senack 7/0
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 3 0 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MATILDA KANIS				2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1982 2b. HOUR 7:45P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 29, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) POLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) SYLVAN MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN MONTGOMERY 13c. CITY OR TOWN ROCKVILLE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 6111 MONTROSE ROAD							
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN FELDER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA DEVINSKY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 067-03-0224		17. INFORMANT 20 PEBBLE RIDGE COURT LESTER A. KANIS, POTOMAC, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Cerebrovascular Pathosis DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular Pathosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Insufficiency				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 15 yrs			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 19 82 to May 17 82, that (I) (we) lost saw the deceased alive on May 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE Merton L. White MD DEGREE covering MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 May 82	
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 5/20/1982		23c. NAME OF CEMETERY OR CREMATORY NEW MONTEFIORE CEMETERY	
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				23d. LOCATION FARMINGDALE, LONG ISLAND, NEW YORK		25a. DATE REC'D. BY REGISTRAR MAY 24 1982	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div style="display: flex; justify-content: space-between;"> <div> 1. FOR STATE REGISTRAR </div> <div> CERTIFICATE OF DEATH </div> <div> 8 2 1 3 3 0 6 </div> </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH CAMP KEACH						2a. DATE OF DEATH MONTH DAY YEAR May 29 1982		2b. HOUR 7⁴⁵ AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Dee Hammer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Camp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 03 1100		17. INFORMANT ADDRESS June Boulden Same as #13 (Daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4960								DUE TO, OR AS A CONSEQUENCE OF	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) Severe chronic obstructive lung disease	
DUE TO, OR AS A CONSEQUENCE OF								(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from June 31 1982 to May 29 1982 , that (1) (we) last saw the deceased alive on April 18 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.									
22b. SIGNATURE DEGREE				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Attending Physician MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/2/82		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland	
24. FUNERAL DIRECTOR'S NAME Francis Gasch's Sons Funeral Home, P.A.				25. DATE REC'D. BY REGISTRAR JUN 1 1982		26. REGISTRAR'S SIGNATURE			
Hyattsville, Maryland									

1330

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

Don't know

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove embossed paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 2 1 3 3 0 7 REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		GLADYS MAY KEANE					5/14/1982					7:15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		BLACK		7 31 1999		82		YES		MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
JAMAICA		JAMAICA				MONTGOMERY, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PK.		WASH-ADVENT. HOSP.						HOUSEWIFE		Unknown		
13a. STATE		13b. STREET ADDRESS						13c. STREET ADDRESS				
Maryland		Montgomery TAKOMA PARK						11338 Evans Trail Beltsville, Md.				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Frederick		Frances		No		Unknown		Daphne H, Keane(Dau.) same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular accident</u> (c) <u>Hypertensive cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5/9/82, to 5/14/82, that (I) (we) lost saw the deceased alive on 5/13/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
VIVEK C VAID M.D.		M.D.		X				5-14-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
		7676 N. Hampshire Ave Langley Park										
23a. BURIAL, CREMATION, REMOVAL (CHECK)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		5-23-82		Keane Family Plot		St. Elizabeth, Jamaica						
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Vann & Williams, 4804 Ga. Ave., N.W. Wash, DC		MAY 19 1982		James J. Keane								

Trial

5-27-82

Keane Family Plot

St. Elizabeth, Jamaica

No

Unknown

Edythe H. Keane (Daughter) as 13

Frederick

Plummer

Frances

Colonial

Montgomery Park

Belleville, N.

1138 Evans Trail
Unknown

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13308	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELINORE E. Kennedy										MONTH DAY YEAR 5 29 82	
3. SEX Female										2b. HOUR 700 AM	
4. RACE White										2c. DATE PRONOUNCED DEAD	
5. DATE OF BIRTH MONTH DAY YEAR 4 4 34										MONTH DAY YEAR 5 29 82	
6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS.										2d. HOUR 700 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.										7b. CITIZEN OF WHAT COUNTRY? United States	
7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide										12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Maryland										13b. CITY OR TOWN Montgomery	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET ADDRESS 1400 Fenwick Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Cecil Baker										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian R. Quigley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 217-42-4184	
17. INFORMANT J. Julius Baker										ADDRESS 8816 Westland Drive Gaithersburg, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (b) FALL AT Home DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Turners Syndrome.											
19a. DATE OF OPERATION 5-25-82.										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Subdural Hematoma.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH FELL at Home, slipped.											
21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 6:23 19 82											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL at Home, slipped.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home											
21f. LOCATION STREET OR TOWN COUNTY STATE 8816 North Westland Dr. Gaithersburg Montgomery MD											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Tauber TITLE (SPECIFY) _____ M.D. _____ MEDICAL EXAMINER										DATE SIGNED 5-29-82	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 Wisconsin Ave Bethesda											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE June 1, 1982	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park										23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland										25a. DATE REC'D BY REGISTRAR JUN 3 1982	
25b. REGISTRAR SIGNATURE <i>[Signature]</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 0 9			
1. FOR STATE REGISTRAR										2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myra I. Kibler										MONTH DAY YEAR 05-03-82		901 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 16 94		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plant Worker		12b. KIND OF BUSINESS OR INDUSTRY Musselman Co.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
13a. STATE West Virginia		13b. COUNTY Berkeley		13c. CITY OR TOWN Ridgeway									
14. FATHER'S NAME FIRST MIDDLE LAST Adam B. Specht					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Ritter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-1701		17. INFORMANT ADDRESS 198 12th Street Peggy June Harley Laurel, MD 20707									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE J. G. A. B. J.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. A. B. J.					22e. ADDRESS 1109 Sp... 57... Silica Sp...								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Paynes Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ridgeway Berkeley W.Va.							
24. FUNERAL DIRECTOR NAME Omps Funeral Home, Inc.					ADDRESS 1600 Amherst St. Winchester, VA 22601		25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE Name				

VE 081 21

THE CHAIRMAN

400 071 21

1. The first item on the agenda is the report of the Chairman of the Committee on the Administration of the Department of the Interior. The Chairman will report on the progress of the work of the Committee during the past year. The report will cover the work of the Committee in the areas of land management, conservation, and Indian affairs. The Chairman will also report on the work of the Committee in the areas of research and education. The report will be presented to the Department of the Interior and will be made available to the public.

2. The second item on the agenda is the report of the Chairman of the Committee on the Management of the National Forest System. The Chairman will report on the progress of the work of the Committee during the past year. The report will cover the work of the Committee in the areas of land management, conservation, and Indian affairs. The Chairman will also report on the work of the Committee in the areas of research and education. The report will be presented to the Department of the Interior and will be made available to the public.

3. The third item on the agenda is the report of the Chairman of the Committee on the Management of the National Wildlife Refuge System. The Chairman will report on the progress of the work of the Committee during the past year. The report will cover the work of the Committee in the areas of land management, conservation, and Indian affairs. The Chairman will also report on the work of the Committee in the areas of research and education. The report will be presented to the Department of the Interior and will be made available to the public.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. People who are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
<div style="display: flex; justify-content: space-between;"> <div> <p>4 3</p> <p>1- FOR STATE REGISTRAR</p> </div> <div> <p>8 2 1 3 3 1 0</p> <p>REG. NO.</p> </div> </div>										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR
FIRST MIDDLE LAST BERNARD NMI KING					MONTH DAY YEAR MAY 04 1982					1:00a _M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
male		CAUCASIAN		MAY 10 1920		61		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
WEST VIRGINIA		US				MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		NATIONAL NAVAL MEDICAL CENTER				Gunnery Sgt.		USMC		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
13a. STATE COUNTY VIRGINIA ARLINGTON					13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. 3617 Madison Lane			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BERNARD KING					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY JANE LEMLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			
YES		1940-1960		510-14-2272			MARY KING 3617 MADISON LANE BAILEYS CROSS-ROADS, VA. 22041			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: RESPIRATORY FAILURE										
IMMEDIATE CAUSE (a)										
1991 DUE TO, OR AS A CONSEQUENCE OF METASTATIC SQUAMOUS CELL CANCER										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3 MAY 19 82 to 4 MAY 19 82, that (I) (we) last saw the deceased alive on 4 MAY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. Lester Reed Lt MC USN					DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. LESTER REED, LT, MC, USNR					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			5-4-82		
22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Cremation		May 5, 1982		Metropolitan Crem.		Alexandria, Virginia				
24. FUNERAL DIRECTOR Ives Funeral Home NAME ADDRESS 2847 Wilson Blvd., Arlington, VA 22201					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
					MAY 11 1982					

BP

NOT TO BE
REPRODUCED
WITHOUT
PERMISSION
OF THE
AUTHORITY

Copyright © 1964 by
The McGraw-Hill Companies, Inc.
All rights reserved.
Printed in the United States of America
Library of Congress Catalog Card No. 64-12345
ISBN 0-07-012345-6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be called to the place.

BP _____

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1. STATE REGISTRAR					7 2 1 3 3 1 1 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST Sarah MIDDLE Kirsch LAST Kirsch					MONTH 5 DAY 31 YEAR 82 HOUR 5 MIN 26				
3 SEX Female		4 RACE White		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
				MONTH Jan. DAY 11, YEAR 1909		73 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Clerk		US Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
								8201 - 16th Street	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST David MIDDLE -- LAST Rook					FIRST Bessie MIDDLE -- LAST Levitan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No ---					032-45-5016		Seymour Rook, 224-30, 77th Ave., Bayside, LI, N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for 101, 102, and 103. PART I. DEATH WAS CAUSED BY.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4291 IMMEDIATE CAUSE (a) Acute Myocardial Disease									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Lymphoma									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-31-82 to 5-31-82 and that (my) (our) opinion death occurred on the date and hour (and from the causes stated above, (I) (we) (we) did not view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Carroll D. Mahoney					M.D.		6-1-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Carroll D. Mahoney									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial/Transit			6/2/82		Mt. Judah Cemetery		Queens, New York STATE		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.					25. RECORD BY REGISTRAR				
NAME ADDRESS					1802				
5130 Wisconsin Ave., NW, Washington, D.C. 20016									

11-18-31

2-2-31

11-18-31 11-18-31 11-18-31

11-18-31 11-18-31 11-18-31

11-18-31 11-18-31 11-18-31

11-18-31

11-18-31 11-18-31 11-18-31

11-18-31 11-18-31 11-18-31

11-18-31 11-18-31 11-18-31

11-18-31 11-18-31 11-18-31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 2 1 3 3 1 2					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Bak-Han Koh						2a. DATE OF DEATH MONTH DAY YEAR May 25 1982				2b. HOUR 1:10 P.M.					
3. SEX Male		4. RACE Korean		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Korea		7b. CITIZEN OF WHAT COUNTRY? Perm. Resident		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal		12b. KIND OF BUSINESS OR INDUSTRY School							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 95 Dawson Ave							
14. FATHER'S NAME FIRST MIDDLE LAST Duk Hwan Koh						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sung Sook Choi									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None				16b. SOCIAL SECURITY NO. 105 58 5424		17. INFORMANT 12606 Eldridge St. S.S. Md. Sughok K. Chun (Daughter)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>4860</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 days</i>										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Chronic Heart Condition due to CVA</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (1) (this hospital) attended the deceased from <i>4/6/82</i> 19 to <i>5/25/82</i> 19, that (1) (we) last saw the deceased alive on <i>5/20/82</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (we) did not) saw the body after death.															
22a. SIGNATURE <i>Henry Scruggs</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <i>5/25/82</i>							
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Scruggs						22d. ADDRESS 5413 W. Cedar Lane Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/29/82		23c. NAME OF CEMETERY OR CREMATORY Norbeck Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Norbeck Mont. Md.							
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H. Ave. S.S. Md.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 27 1982 <i>Thomas J. Kistner</i>							

1 2 3 4 5

MAY 19 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR Kathryn G. Kokkinis					REG. NO. 8 2 1 3 3 1 3				
1. DECEASED NAME (TYPE OR PRINT) KATHRYN G. KOKKINIS					2a. DATE OF DEATH MONTH 5 DAY 2 YEAR 82 2b. HOUR 11 39 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July DAY 17 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5480 Wisconsin Avenue	
14. FATHER'S NAME FIRST Loukas MIDDLE --- LAST Kugopoulos					15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE --- LAST Kopidou				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-54-1717		17. INFORMANT ADDRESS George Kokkinis - 5480 Wisconsin Ave. Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Massive 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR N/A A.M. MONTH N/A DAY N/A YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) N/A		21f. LOCATION STREET N/A CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 4 19 81 , to May 2 19 82 , that (I) (we) last saw the deceased alive on May 2 19 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Geo T. Economos MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 5/2/1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEO T. ECONOMOS					22e. ADDRESS 2141 K ST NW Wash. D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/5/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring Md. COUNTY STATE			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Avenue, N.W.-Washington, D.C.					25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	1222	1223	1224	1225	1226	1227	1228	1229	1230	1231	1232	1233	1234	1235	1236	1237	1238	1239	1240	1241	1242	1243	1244	1245	1246	1247	1248	1249	1250	1251	1252	1253	1254	1255	1256	1257	1258	1259	1260	1261	1262	1263	1264	1265	1266	1267	1268	1269	1270	1271	1272	1273	1274	1275	1276	1277	1278	1279	1280	1281	1282	1283	1284	1285	1286	1287	1288	1289	1290	1291	1292	1293	1294	1295	1296	1297	1298	1299	1300	1301	1302	1303	1304	1305	1306	1307	1308	1309	1310	1311	1312	1313	1314	1315	1316	1317	1318	1319	1320	1321	1322	1323	1324	1325	1326	1327	1328	1329	1330	1331	1332	1333	1334	1335	1336	1337	1338	1339	1340	1341	1342	1343	1344	1345	1346	1347	1348	1349	1350	1351	1352	1353	1354	1355	1356	1357	1358	1359	1360	1361	1362	1363	1364	1365	1366	1367	1368	1369	1370	1371	1372	1373	1374	1375	1376	1377	1378	1379	1380	1381	1382	1383	1384	1385	1386	1387	1388	1389	1390	1391	1392	1393	1394	1395	1396	1397	1398	1399	1400	1401	1402	1403	1404	1405	1406	1407	1408	1409	1410	1411	1412	1413	1414	1415	1416	1417	1418	1419	1420	1421	1422	1423	1424	1425	1426	1427	1428	1429	1430	1431	1432	1433	1434	1435	1436	1437	1438	1439	1440	1441	1442	1443	1444	1445	1446	1447	1448	1449	1450	1451	1452	1453	1454	1455	1456	1457	1458	1459	1460	1461	1462	1463	1464	1465	1466	1467	1468	1469	1470	1471	1472	1473	1474	1475	1476	1477	1478	1479	1480	1481	1482	1483	1484	1485	1486	1487	1488	1489	1490	1491	149
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----

Item #100 per phone call w/Run. Hom STATE OF MARYLAND

1. FOR 5/12/82 rc
STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 3 3 1 4

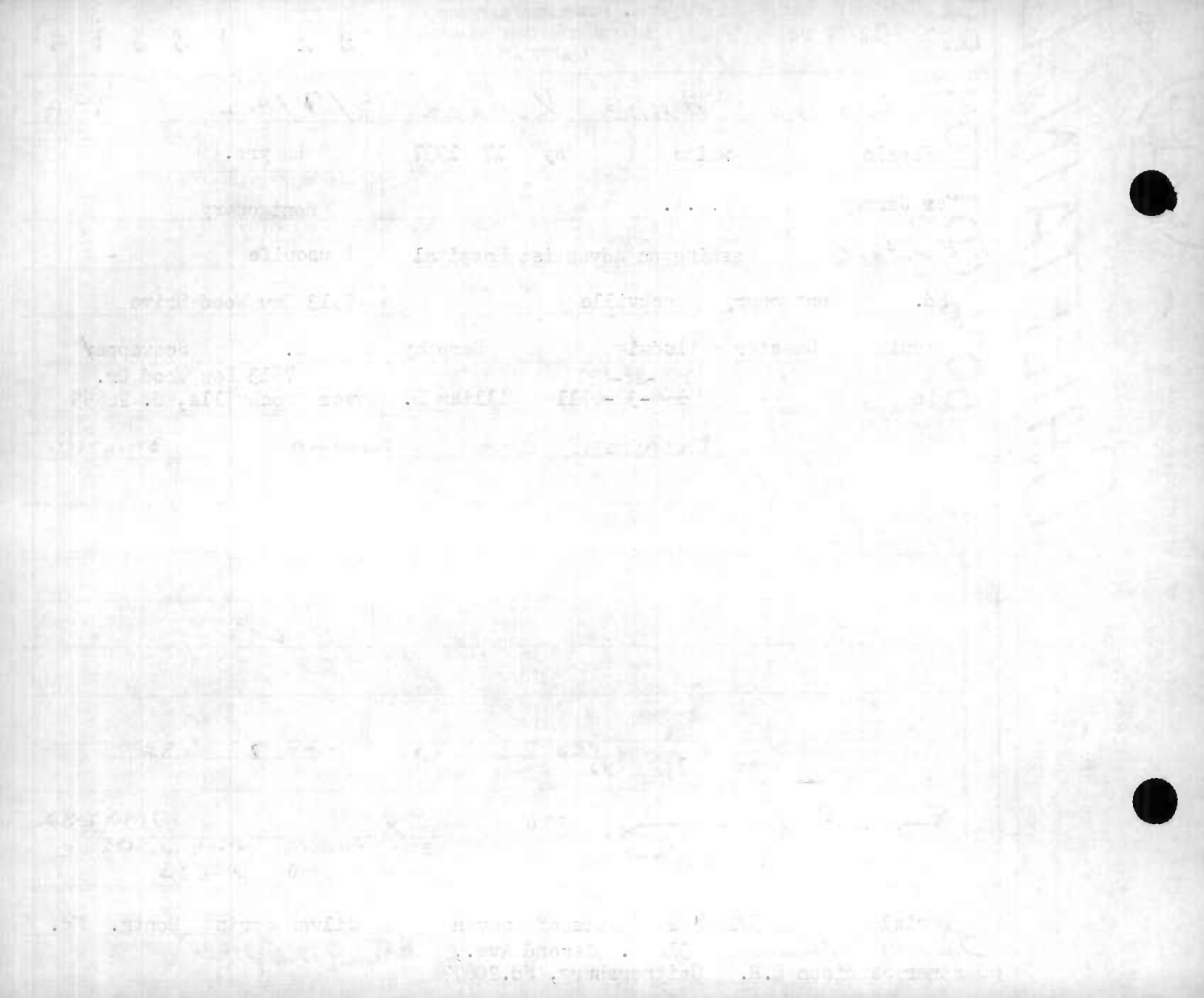
1. DECEASED NAME (TYPE OR PRINT) Laura Anne Kovacs			2a. DATE OF DEATH MONTH DAY YEAR 5/7/82		2b. HOUR 2²⁵ A M
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 17 1937	6. AGE (IN YEARS LAST BIRTHDAY) 44 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7513 Dew Wood Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Chester Ludwig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy E. Schwepper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 158-26-8711 158-38-8711		17. INFORMANT 7513 Dew Wood Dr. William D. Kovacs Rockville, Md. 20855	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from FEB , 19 82 , to MAY 7 , 19 82 , that (I) (we) last saw the deceased alive on MAY 7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE Eugene P. Flannery		DEGREE MO		22c. DATE SIGNED 7 MAY 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MO		22e. ADDRESS 1811 PRINCE PHILIP DRIVE OLNEY, MO. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/10/82	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.	
24. FUNERAL DIRECTOR Gartner Sandison F.H.		316 E. Diamond Ave., Gaithersburg, Md. 20877		25a. DATE RECEIVED BY REGISTRAR MAY 12 1982	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

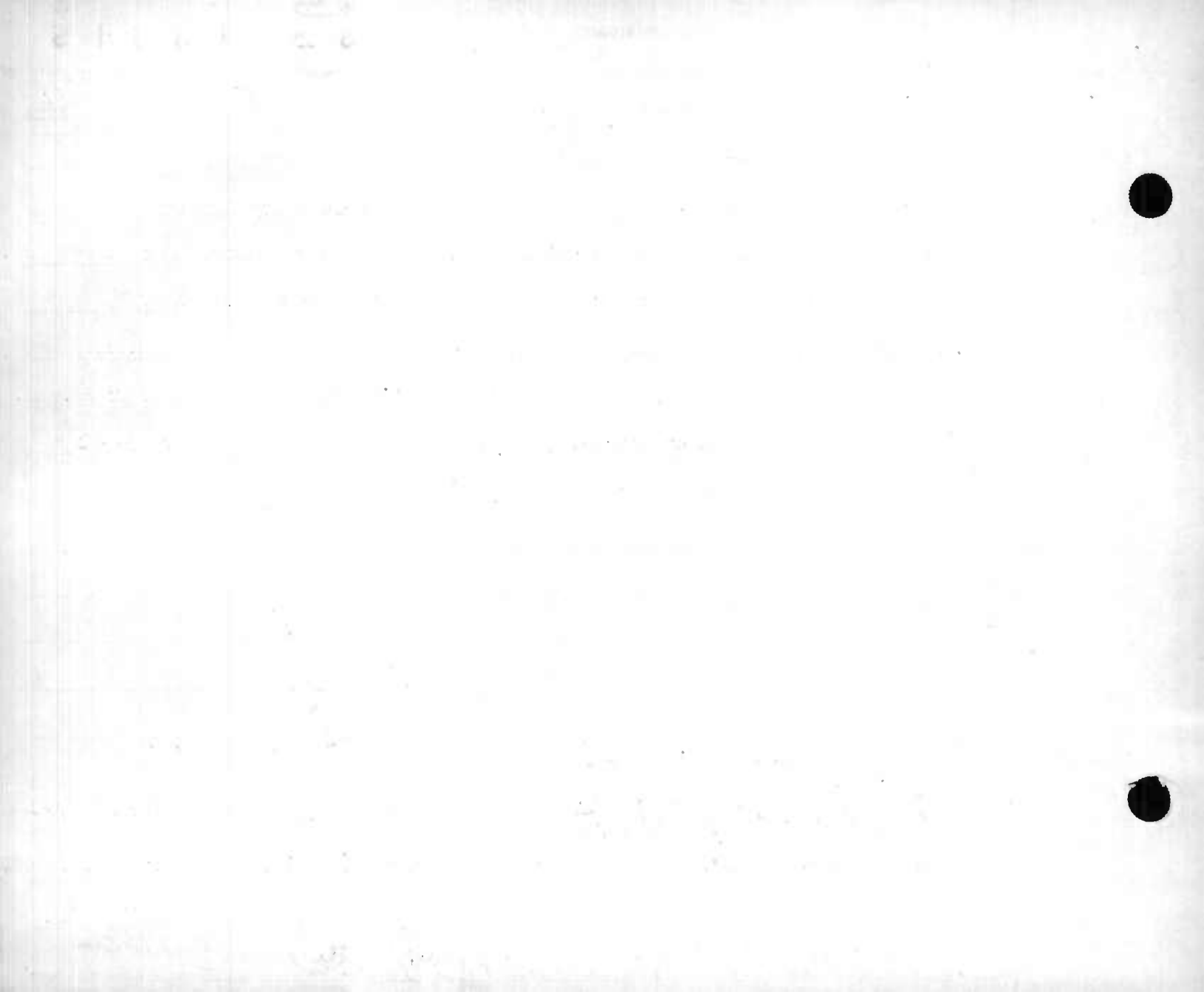
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 1 5			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Kowal					2a. DATE OF DEATH MONTH 5 DAY 3 YEAR 82				2b. HOUR 10:15 AM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH April DAY 30 YEAR 1956		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10150 Brookmoor Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Georgetown Hosp.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10150 Brookmoor Drive						
14. FATHER'S NAME FIRST Stanley MIDDLE J. LAST Kowal					15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE Ann LAST Hurley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-54-6622		17. INFORMANT ADDRESS Ann Kowal 10150 Brookmoor Dr., Silver Sp., Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrocytoma (10-80) 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-3-82			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1982, to MAY 3, 1982, that (I) (we) lost saw the deceased alive on APRIL 29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Richard W. Holt, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED MAY 3 1982					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Holt, M.D.				22e. ADDRESS 3800 Reservoir Rd., N.W., Washington, D.C. 20007									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/6/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE Charles J. Nathan							

BP

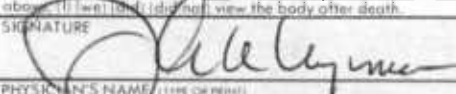



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 2 1 3 3 1 6			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Frederick B. Kraft				2a. DATE OF DEATH MONTH DAY YEAR 5 - 6 82		2b. HOUR 2:23 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 31 1895		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Electrical Engineer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4601 Highland Avenue		14 FATHER'S NAME FIRST MIDDLE LAST Henson Christopher Kraft		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Heller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 1908-1916		17 INFORMANT Anna Ellison		ADDRESS 7601 Chelton Rd. Bethesda, Md. 20814			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive pulmonary dis. DUE TO, OR AS A CONSEQUENCE OF (c) senility APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: senility							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 27 Feb 19 75		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 27 Feb 19 75 to 6 May 19 82 , that (I) (we) last saw the deceased alive on 30 April 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wyman				22e. ADDRESS 7801 Norfolk Ave. Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc.				25a. FILED BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE 	
25c. ADDRESS 1331 Rockville Pike Rockville, Md. 20852							

MEDICAL CERTIFICATION

29

Section 5. Title

Office No. 31 1st

Washington, D.C. 20540

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

Director, Federal Bureau of Investigation

Washington, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. REG. NO. 8 2 1 3 3 1 7							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia L. KREIGER				2a. DATE OF DEATH MONTH DAY YEAR 5/28/82		2b. HOUR 8 ³⁰ PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Vale Laundry	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2205 Belvedere Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand Lange				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hulda M. Wadapohl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577-05-3113		17. INFORMANT ADDRESS Mrs. Julia D. Rives same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 5712 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LIVER CIRCULOSIS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN. <u>1</u> HOURS <u>1</u> YEARS <u>1</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ANEMIA; POST FRACTURED HIP REPAIR</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>5/10</u> , 19 <u>82</u> , to <u>5/28</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>5/22</u> , 19 <u>82</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.									
22b. SIGNATURE Harold W. Draper M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.				22e. ADDRESS 9801 GEORGIA AVE, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/30/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]			
500 University Blvd. W. Silver Spring, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR dad STATE REGISTRAR		7/22/82 21a, b, d, e, 22a G569 7/22/82							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
LOUIS KREIGER		F.		KREIGER		5/19/82		2b. HOUR 10 04 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		CAUCASIAN		JAN 17, 1922		60 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
CONNECTICUT		U.S.A.				MONTGOMERY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		HOLY CROSS HOSPITAL				DLSC		U.S. GOVT.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MICHIGAN		CALHOUN		BATTLE CREEK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		86 HICKORY LANE 49017	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
LOUIS		KREIGER		JULIA LANGE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES		WW II		PATRICIA R. KREIGER SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Stroke Lung - Cardiorespiratory Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Interarterial Hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SKULL FRACTURE</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION									
5/15/82									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
Interarterial Hemorrhage									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
P.M. 5/2/82 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
21g. STREET									
street									
22a. I certify that (I) (this hospital) attended the deceased from 5/15/82, 19 82, to 5/19/82, 19 82 that (I) (we) last saw the deceased alive on 5/19/82, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
Bernard Tjorneho									
22c. DATE SIGNED									
5/19/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
BERNARD Tjorneho MD									
22e. ADDRESS									
SILVER SPRING, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
CREMATION									
23b. DATE									
5/20/82									
23c. NAME OF CEMETERY OR CREMATORY									
METROPOLITAN CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
ALEXANDRIA VIRGINIA									
24. FUNERAL DIRECTOR NAME ADDRESS									
FRANCIS J. COLLINS									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									
25a. DATE REC'D. BY REGISTRAR									
MAY 24 1982									
25b. REGISTRAR'S SIGNATURE									
Name [Signature]									

BP



8 5 1 2 1 8

2/12/68 KAC/MA

2-12-68
KAC/MA
2-12-68

2-12-68 KAC/MA

2-12-68

2-12-68

2-12-68

2-12-68

2-12-68 KAC/MA

2-12-68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) 0/8a		FIRST	MIDDLE	LAST KRUGER XXXXXXXXXX	2a. DATE OF DEATH MONTH DAY YEAR 5 15 82		2b. HOUR 11:20 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 27 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Pr. Georges Hyatts.,					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7415 17th. Avenue,		

4. FATHER'S NAME MIDDLE Rudolph Klose		15. MOTHER'S MAIDEN NAME MIDDLE Mathilda Nickel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --	
17. INFORMANT ADDRESS Walter Kruger-son-Pkwy, 2361 Jefferson Davis Arl., Va.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7855 DUE TO, OR AS A CONSEQUENCE OF (b) Sept 2 Shock DUE TO, OR AS A CONSEQUENCE OF (c) 3 hours		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours	
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 15 May 1982, to 15 May 1982, that (1) (we) lost saw this deceased alive on 15 May 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael Libowitz, MD				DEGREE MD		22c. DATE SIGNED 15 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Libowitz, MD				22e. ADDRESS 1120 New Hampshire Ave. S. Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-20-82		23c. NAME OF CEMETERY OR CREMATORY Mennonite Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE East Petersburg Pa.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 11800 N.H. Ave. S.S. Md. MAY 20 1982 Thomas J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 2 0			
1. FOR STATE REGISTRAR		2. REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) BESSIE MAY KUDOLLA						2a. DATE OF DEATH MONTH DAY YEAR MAY 9 82		2b. HOUR 5:30 A					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 25 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE MD				13b. COUNTY Washington, DC		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Gill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Downing									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Silver Spring, Md. Florence L. Denham 1804 Everest St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ADVANCED RHEUMATOID ARTHRITIS + URINARY TRACT INFECTION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR APRIL 27 19 82 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5413 CEDAR LANE, BETHESDA									
22a. I certify that (I) (this hospital) attended the deceased from MAY 7 19 82 to MAY 9 19 82 that (I) (we) last saw the deceased alive on MAY 7 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R.C. Daddario				DEGREE MD				22c. DATE SIGNED 5/9/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.C. DADDARIO				22e. ADDRESS 5413 CEDAR LANE, BETHESDA									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/82		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery, Washington, D.C.				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL HOME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

BP

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

Item 5 g567 5/28/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 2 1

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Genevieve S. Kukowski			2a DATE OF DEATH MONTH DAY YEAR 5/19/82 5 19 82			2b HOUR 7 AM	
3 SEX female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR March 31, 1982		6 AGE (IN YEARS LAST BIRTHDAY) 49 days	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery CO MD	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 412 Colesville Manor Dr.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland				13c CITY OR TOWN Montgomery Sil.Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Richard G.P. Kukowski				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elaine Klein			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) --		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17 INFORMANT father Richard G.P. Kukowski-(sm. as 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Failure</u> 7582 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke 18 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 5/12 19 82, to 5/19 19 82, that (I) (we) last saw the deceased alive on 5/12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Marvin TABB</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/19/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN TABB				22e ADDRESS 2401 Blueridge Ln SS Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-21-1982		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave S. S. Md.		25 DATE REC'D. BY REGISTRAR MAY 20 1982	
				26 REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			

12550

[illegible][illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 3 2 2			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>MOLLY</u> MIDDLE <u>M.</u> LAST <u>KULDELL</u> <u>Molly M. Kuldell</u>				2a. DATE OF DEATH MONTH <u>5</u> DAY <u>13</u> YEAR <u>82</u> 2b. HOUR <u>4:35</u> AM			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>Jan.</u> DAY <u>24</u> YEAR <u>1899</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. STATE <u>D.C.</u>		13c. CITY OR TOWN <u>Washington</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>3615 Davis St., N.W.</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Leonard</u> LAST <u>Mason</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Julia</u> MIDDLE <u>Ann</u> LAST <u>Ross</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>579-38-1079</u>		17. INFORMANT ADDRESS <u>Potomac, Md.</u> <u>Philip D Kuldell, 12310 Glen Mill Road,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>2252</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningioma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 28</u> , 19 <u>82</u> , to <u>May 13</u> , 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>May 12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sidney J. Chan, M.D.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/13/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sidney J. Chan, M.D.</u>				22e. ADDRESS <u>121 Congressional Lane, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/15/1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION <u>Brentwood, Maryland.</u> STATE	
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons Inc.</u> <u>5130 Wisc. Ave., N.W. ash., DC.</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 17 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Garrison</u>	

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward S. LaBuda			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1982			2b. HOUR PM 10:04				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 19		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wash. Post		12b. KIND OF BUSINESS OR INDUSTRY Mailer		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12512 Winexburg Manor Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen J. LaBuda			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Puhalla							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII		17. INFORMANT ADDRESS 196 07 6439 Dorothy LaBuda (Wife) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5192 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Overwhelming Sepsis (c) Mediastinitis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 47 Days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure, Cardiorespiratory Failure										
19a. DATE OF OPERATION 4/3/82-4/20/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cecal Dilatation			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/7/82 5:10/82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/3 , 19 82 , to 5/20 , 19 82 , that (I) (we) last saw the deceased alive on 5/20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>K.F. Cheyney</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 20, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.F. Cheyney						22e. ADDRESS 18111 Pr. Philip Dr. Olney, Dr.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/24/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi						ADDRESS 11800 N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR MAY 27 1982		

Handwritten text at the bottom left, possibly a signature or date.

Vertical text on the right side, possibly a page number or reference.

Large vertical text on the far right, possibly a page number or reference.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 3 2 4 REG. NO.				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) <u>EDYTHE</u> ^{FIRST} <u>MAE</u> ^{MIDDLE} <u>LAMBORNE</u> ^{LAST}				5-1-82				10:00 PM
3 SEX <u>Female</u>		4 RACE <u>Cauc.</u>		5 DATE OF BIRTH <u>JUNE 15 91</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.		
10 CITY OR TOWN OF DEATH <u>Sandy Spring, Md</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Friends Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>H.WIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>
13a. STATE <u>MARYLAND</u>				13b. COUNTY <u>MONT.</u>		13c. CITY OR TOWN <u>OLNEY</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME <u>Henry</u> ^{FIRST} <u>KAISER</u> ^{MIDDLE} <u>KAISER</u> ^{LAST}				15 MOTHER'S MAIDEN NAME <u>ELIZABETH</u> ^{FIRST} <u>STIGLER</u> ^{MIDDLE} <u>STIGLER</u> ^{LAST}				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>578-10-2392B</u>		17 INFORMANT ADDRESS <u>Roger Lamborne Brookeville, Md.</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4380</u> <u>Inanition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Paralysis due to CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Paralysis due to CVA 10 yrs</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/82</u> to <u>5/1/82</u> , that (I/we) last saw the deceased alive on <u>5/1/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>5/1/82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. H. Ligon</u>				22e. ADDRESS <u>1811 P & Phyllis Dr Olney Md 20852</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>MAY 4, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland P. George Md.</u>		
24. FUNERAL DIRECTOR <u>FRANCIS H. BARBER</u>				LAYTONSVILLE, MD. 20879		25a. DATE RECEIVED BY REGISTRAR <u>MAY 8 1982</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked essential, there must be any injury, or other traumatic event, the medical examiner must be notified at once.

APPROVED BY MEO DR. ROGERS 5/29/82 AT 12:15 AM RELEASED TO DR. GOLDENBERG

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) ANNA M (ASIMINA) S. LAMBROS					2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1982					2b. HOUR 10 ⁰⁰ PM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR October 18, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tripoli, Greece		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) at home		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Montgomery Chevy Chase		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Vasililos Stavropoulos					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angeliki Hronopoulos					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					16b. SOCIAL SECURITY NO. 218-52-6643-J		17. INFORMANT Demetrios S. Lambros Chevy Chase, Md. 20815			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis 10 YRS. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Heart Disease										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/23/82 to 5/28/82, that (I) (we) last saw the deceased alive on 5/23/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE David Goldenberg MD					22c. DATE SIGNED MAY 29, 1982			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDENBERG MD					22f. ADDRESS 9801 GEORGIA AVE. SILVER SPRINGS, MD. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 1, 82		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. 5130 Wisc. Av. NW Washington, D. C. 20016					25a. DAY RECEIVED BY REGISTRAR JUN 7 1982					

DEPARTMENT OF THE ARMY, OFFICE OF THE CHIEF OF STAFF, WASHINGTON, D. C. 20315

**

1. The following information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

2. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

3. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

4. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

5. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

6. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

7. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

8. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

9. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

10. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

11. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

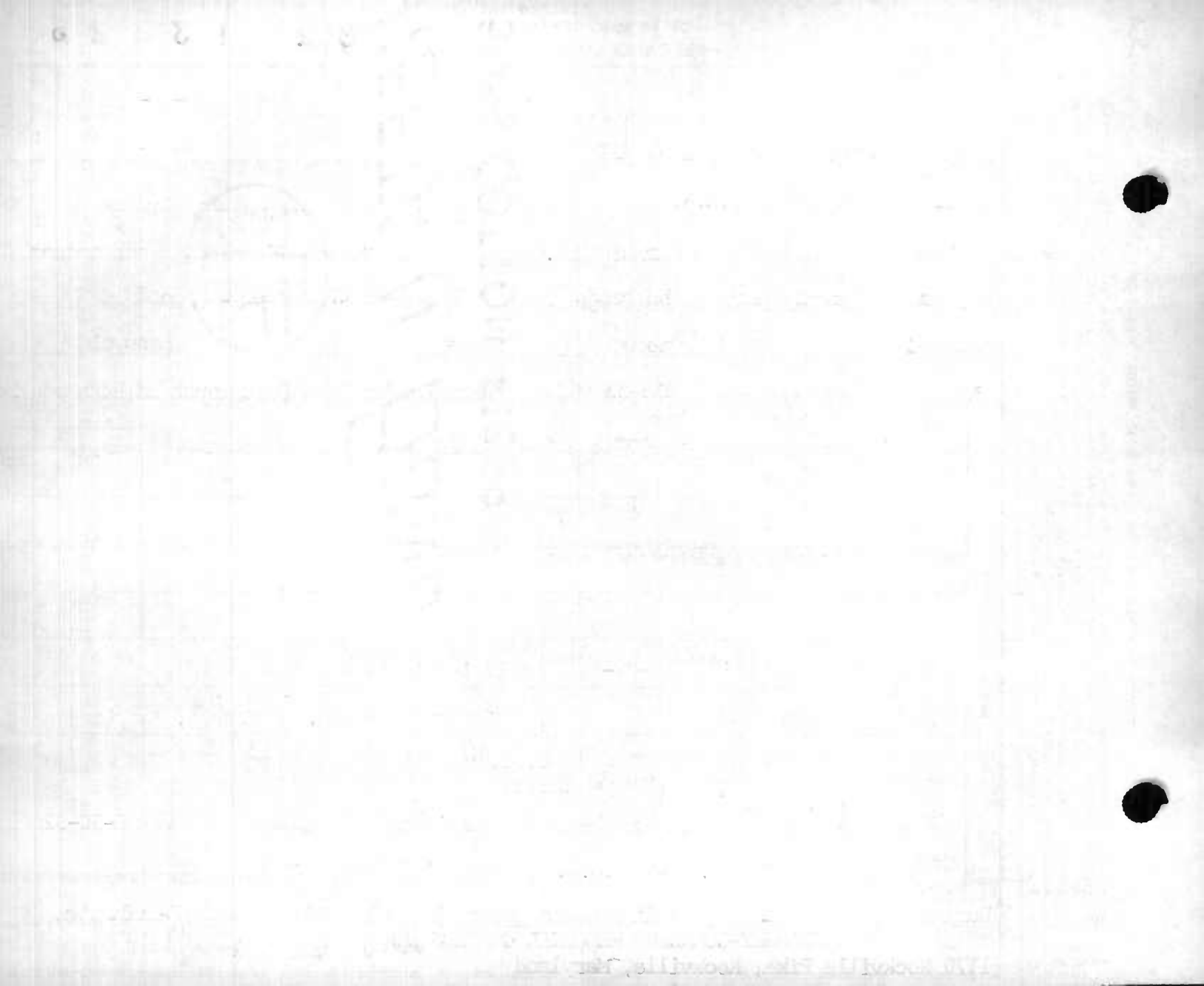
12. The information was received from the Department of the Army, Office of the Chief of Staff, Washington, D. C. 20315, on 10/10/50:

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 1 3 3 2 6	
1. DECEASED NAME (TYPE OR PRINT)		FIRST LYNN		MIDDLE LANDAU		LAST	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2a. DATE KNOWN OF DEATH	2b. HOUR
Female	Cauc.	May 19, 1950	32 YRS.			<input checked="" type="checkbox"/> MONTH DAY YEAR 5-29-82 19	4:10P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Seattle, Washington	U.S.A.			Montgomery County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda	5206 Portsmouth Rd.			Homemaker		-----	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5206 Portsmouth Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Richard Gebow		Mona Rosowold					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		539-52-9536		Alan Landau; 5206 Portsmouth Rd; Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		5:00PM MONTH DAY YEAR 5-29-82 P.M.		self/inflicted			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
		home		5206 Portsmouth Rd. CITY OR TOWN Bethesda, COUNTY Maryland STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
<i>Margareta A. Korell</i>		M.D. Assistant		MEDICAL EXAMINER 5-30-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Margarita A. Korell, M.D.		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		June 2, 82		King David Memorial Garden; Falls Church; Fairfax; Va.		CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG MEMORIAL CHAPEL		JUN 3 1982		<i>James J. [Signature]</i>			
1170 Rockville Pike; Rockville, Maryland							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 3 3 2 7 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Leonard M. LaRue					2a. DATE OF DEATH MONTH DAY YEAR 5 24 82			2b. HOUR 12:20 ^A	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Hyman Const.	
13a. USUAL RESIDENCE STATE COUNTY CITY OR TOWN Maryland Montgomery Silver Spr					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 2400 Briggs Chaney Road,		
14. FATHER'S NAME FIRST MIDDLE LAST Randolph La Rue					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lovie Decker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Edith M. La Rue-wife-(same as 13c)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis shock 5188 DUE TO, OR AS A CONSEQUENCE OF (b) aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Diphtheria, pulmonary PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic myeloid leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 48 hr. 2-3 yrs
19a. DATE OF OPERATION 4/11/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED breast, thyroid, spleen			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from Sept 1 , 19 82 , to July 7 , 19 82 , that (1) (we) last saw the deceased alive on July 7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. Chler					22e. ADDRESS 3915 Furman Dr Wheaton				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-27-82		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Montg. Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home					ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE [Signature]

Walter May 13, 1907

2400 Highway Quarry Road

Highland Cemetery Silver Spring

Reckon

to the

Highland

214-03-2810 High St. La Fve-ville (near 11th)

Highland Cemetery Silver Spring
11300 N.E. Ave.
May 27 1907
Walter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 2 8 REG. NO.	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) Angelina Lassiter					2a DATE OF DEATH MONTH DAY YEAR May 20 1982			2b HOUR 7:10 A			
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Sept. 25 191		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18540 Bowie Mill Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY Federal Govt.			
13a STATE Maryland										13b COUNTY Montgomery	
14 FATHER'S NAME FIRST MIDDLE LAST Francesco		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Santina Castalani		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 18540 Bowie Mill Road,			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17 INFORMANT 525-42-5383 David Lassiter-son-(same as 13e)		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma R lung</i> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>metastasis to liver & primary brain.</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>8 Sept. 1982</u> to <u>20 May 1982</u> , that (I) was lost saw the deceased alive on <u>12 Apr. 1982</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.											
22b SIGNATURE <i>Donald E. Dillon MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 20 May 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Dillon, MD.				22e ADDRESS 18111 Prince Phillip Dr., Olney, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.					
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave. S.S. Md.				DATE REC'D. BY REGISTRAR MAY 27 1982			

1 3 3 2 0

Handwritten

Handwritten

Handwritten

USA

Handwritten

10340 Route Mill Road

Handwritten

Handwritten

Handwritten

Handwritten

321-42-2003 David L. Laster, con. (name as 130)

Handwritten

Handwritten

Handwritten

Handwritten

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 2 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice Virginia Lawrence			2a. DATE OF DEATH MONTH DAY YEAR May 18, 1982		2b. HOUR 5:00p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 17, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	# UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth., Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Indiana			13b. COUNTY Jefferson	13c. CITY OR TOWN Madison	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Herbert mnm Kent			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Goldie mnm Jenkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS William G Lawrence (husband) Same as Patient	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (b) MALNUTRITION 2° TO Dysphagia DUE TO, OR AS A CONSEQUENCE OF (c) SQUAMOUS CELL CA OF ESOPHAGUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1509				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks + 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: OBESITY / ETOH ABUSE / 125 pack year smoking history					
19a. DATE OF OPERATION 5/4/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal CARCINOMA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR April 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) April		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 14 , 19 82 , to May 18 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 18 , 19 82 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (d) XXXX view the body after death.					
22b. SIGNATURE Joe B Putnam, Jr MD		DEGREE MD		22c. DATE SIGNED 5/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOE B PUTNAM, JR MD		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-24-1982	23c. NAME OF CEMETERY OR CREMATORY Grandview Mem Gard, Madison, Jefferson, Indiana	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS W. W. Chambers Co, 8655 Georgia Ave, SILSpG		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 24 1982 <i>James J. [Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 3 3 2 2

Alison (Mrs) [illegible]

Female

White

Age 37, 1908

Height

5' 6"

Weight 120 lbs

Complexion

Light brown

Blue eyes

Build

Slender

Thin

Dark hair

Married

Yes

Single

Never

Widow

Address

311-11

100 William Street (London) W.C. 2

Mr. A. C. [illegible] [illegible]

100 William Street

London W.C. 2

100 William Street

100 William Street

100 William Street

100 William Street

100 William Street

100 William Street

100 William Street

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
15A/2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13330	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Annie E. Lee										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH May DAY 16 YEAR 1982	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH Jan DAY 30 YEAR 1948		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR 2 M PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D. C.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD May 16 1982 M PM	
10. CITY OR TOWN OF DEATH Salt Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2821 Hethaway Ter				12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Retired Government Worker.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY Montgomery		13c. CITY OR TOWN Salt Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7051 CARROLL AVENUE	
14. FATHER'S NAME Samuel W. Keys.						15. MOTHER'S MAIDEN NAME Mary Scanlon.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 579-62-9271		17. INFORMANT 5301 Quincy St. Address: Louis Miller. (Nephew)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M.D.						TITLE (SPECIFY) Def.			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS			DATE SIGNED May 16, 1982		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.				23b. DATE May 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION CITY OR TOWN Suitland Rd. P. G. Co., State Md.		
24. FUNERAL DIRECTOR 254 Carroll St. N. Takoma Funeral Home.						DATE REC'D BY REGISTRAR MAY 19 1982			25b. REGISTRAR'S SIGNATURE James J. ...		

gey

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 8 2 1 3 3 3 1									
1. DECEASED NAME (TYPE OR PRINT)		FIRST LEO		MIDDLE (NMN)		LAST LEIFER		2a. DATE OF DEATH MONTH DAY YEAR May 31, 1982		2b. HOUR 10:50p M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 25, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) T. V. Repair		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia		13b. COUNTY		13c. CITY OR TOWN Hampton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 706 Milton Drive			
14. FATHER'S NAME FIRST MIDDLE LAST David Leifer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Brunwasser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 133-05-2951		17 INFORMANT ADDRESS Irene Leifer, wife - same							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF, (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (c) Diffuse histiocytic lymphoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs 6 months 34 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from May 30, 1982, to May 31, 1982, that (we) last saw the deceased alive on May 31, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/1/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY MASUR		22e. ADDRESS National Institutes of Health CLINICAL CENTER, Bethesda, Md 20205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1982		23c. NAME OF CEMETERY OR CREMATORY Hebrew Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampton, Virginia					
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) Peninsula Funeral Home		1144 Warwick Blvd		Newport News, Va.		25a. DATE REC'D. BY REGISTRAR JUN 8 1982		25b. REGISTRAR'S SIGNATURE			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director and should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be a full autopsy.

1 3 2 1 1 3 2 1

REGISTRATION

UNITED STATES



01/05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 3 2

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>James Douglas Lever</i>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>May 31 1982</i>		2b. HOUR <i>2:00 PM</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 4 1954</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>28</i>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>May 31 1982</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>	
10. CITY OR TOWN OF DEATH <i>Sandy Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1001 Olney Sandy Spring Rd</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>	
13a. STATE <i>MD</i>		13b. CITY OR TOWN <i>Montgomery</i>		13c. STREET ADDRESS <i>1001 Olney Sandy Spring Rd</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jack Q. Lever</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Franks</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-50-6052</i>		17. INFORMANT ADDRESS <i>Camilla O. McRory, same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i> 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Hanging</i> (c) <i>None</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>							
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5 31 1982</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Hanging</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION CITY OR TOWN COUNTY STATE <i>Olney Sandy Spring Rd Sandy Spring Montgomery MD</i>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>MD</i>		MEDICAL EXAMINER		DATE SIGNED <i>May 31 1982</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>		ADDRESS <i>1919 Seminary Road Silver Spring, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>June 2, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria, Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 2 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James S. Hatcher</i>	

2000

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

2000 S 1000

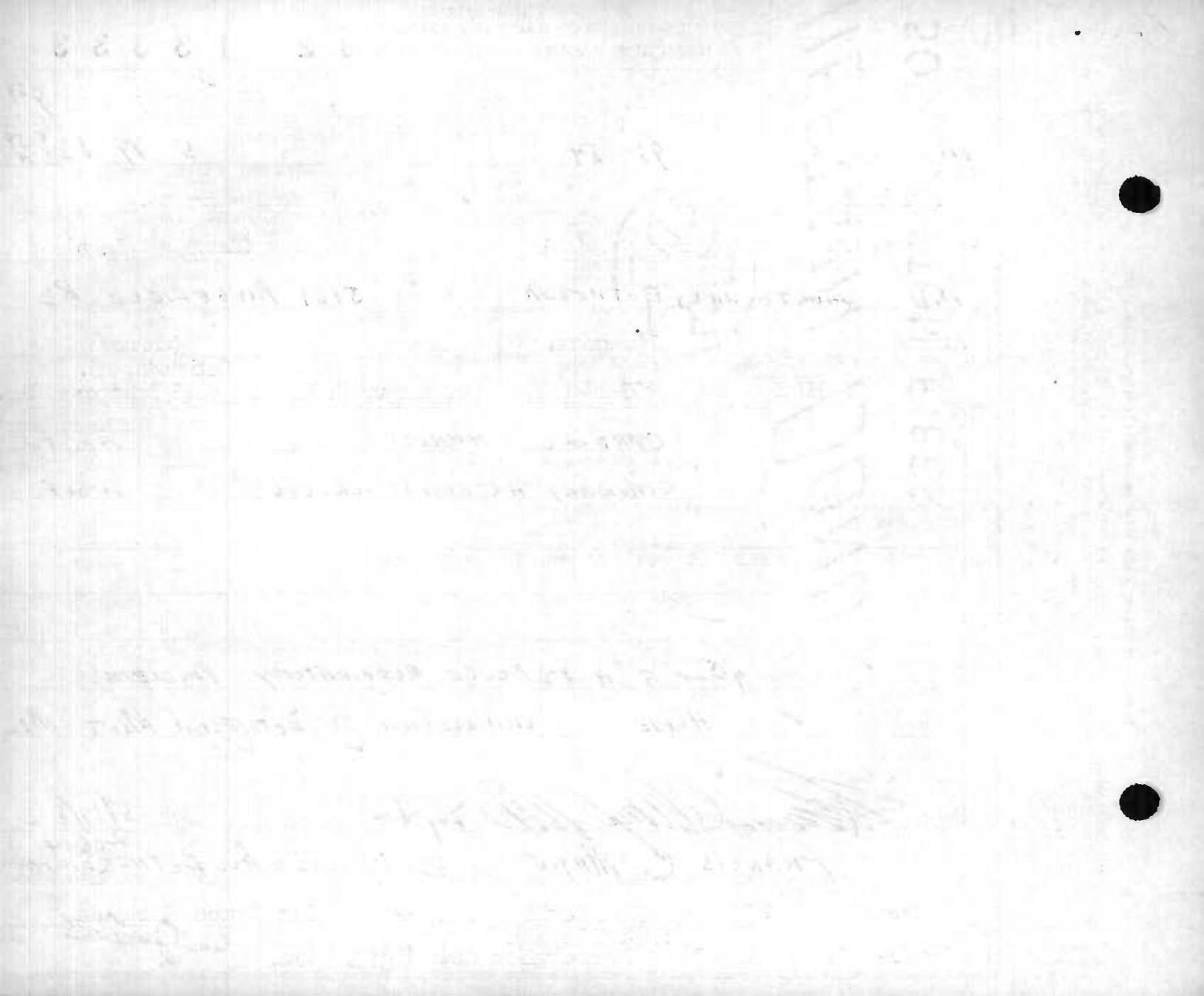
Analysis

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13333	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		2b. HOUR		2c. MONTH DAY YEAR	
		David A. Levine				5/19/1982		9:57		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M		CAUC		1 1 98		84 YRS.		MONTHS DAYS HOURS MIN.		5 19 1982 9:57	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Roumania		USA		WIDOWED		DIVORCED		Montgomery Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda, Md.		Suburban Hospital		Attorney (Ret.)		Legal					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		MONTGOMERY		BETHESDA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5101 RIDGEFIELD RD			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Alfred		Anna		Yes		293-28-1628		Dr. Arthur S. Levine		Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
IMMEDIATE CAUSE (a)											
4140											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b)											
CORONARY ARTERIOSCLEROSIS											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
9:45 AM		5 19 1982		ACUTE RESPIRATORY PROBLEM							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		HOME		5101 RIDGEFIELD RD BETHESDA MONT MD							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion			
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Francis C. Mayle		M.D. Dept.		5/19/82							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
FRANCIS C. MAYLE		2200 Wisconsin Ave Bethesda MD		Burial		5-21-1982		King David Mem. Garden		Falls Church, Virginia	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Danzansky-Goldberg Chapels; 1170 Rockville Pike		MAY 24 1982		Name							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1 (B)
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. DATE OF DEATH		4. DATE OF DEATH		5. DATE OF DEATH		6. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. DATE OF DEATH		4. DATE OF DEATH		5. DATE OF DEATH		6. DATE OF DEATH	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR		MONTH DAY YEAR		MONTH DAY YEAR		MONTH DAY YEAR	
Arthur A. Levy		5-23-82		7A. M		7A. M		7A. M		7A. M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male		White		6 6 97		84 YRS.		MONTHS DAYS HOURS MIN.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH	
Chicago, ILL		USA				Montgomery		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12b. KIND OF BUSINESS OR INDUSTRY		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Chevy Chase Ret. Nursing Ctr.		Merchandise Mgr.		Clothing		Clothing		Clothing	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		13d. STREET ADDRESS		13d. STREET ADDRESS	
D.C.		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2819 Kanawha St. 20015		2819 Kanawha St. 20015		2819 Kanawha St. 20015	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		yes		491-09-4425 A		Hermine L. Dreyfuss.		2851 Davenport St. N.W.	
Soul		Bessie Barnett									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280		18b. SOCIAL SECURITY NO.		18c. CITY OR TOWN		18d. STREET ADDRESS		18d. STREET ADDRESS		18d. STREET ADDRESS	
Congestive heart failure		491-09-4425 A		Washington		2819 Kanawha St. 20015		2819 Kanawha St. 20015		2819 Kanawha St. 20015	
DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
Metastatic carcinoma of prostate		Metastatic carcinoma of prostate		Metastatic carcinoma of prostate		Metastatic carcinoma of prostate		Metastatic carcinoma of prostate		Metastatic carcinoma of prostate	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 19 80, to 5-23, 19 82, that (we) lost saw the deceased alive on 5-20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED	
		James H. Brodsky MD		5-23-82		5-23-82		5-23-82		5-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS		22e. ADDRESS	
James H. Brodsky MD		4701 Willard Ave., Chevy Chase		4701 Willard Ave., Chevy Chase		4701 Willard Ave., Chevy Chase		4701 Willard Ave., Chevy Chase		4701 Willard Ave., Chevy Chase	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		5/24/1982		Cedar Hill Crematory		Suitland Maryland		Suitland Maryland		Suitland Maryland	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
Joseph Gawler's Sons Inc.		Joseph Gawler's Sons Inc.		Joseph Gawler's Sons Inc.		Joseph Gawler's Sons Inc.		Joseph Gawler's Sons Inc.		Joseph Gawler's Sons Inc.	
NAME		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
5130 Wisc. Ave., N.W.		Washington, D.C.		Washington, D.C.		Washington, D.C.		Washington, D.C.		Washington, D.C.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
MAY 25 1982		James H. Brodsky		James H. Brodsky		James H. Brodsky		James H. Brodsky		James H. Brodsky	

4-8-8

very

spring

1.000000

Given during

1.00

Yes



Smithsonian

National Museum

Department of the Interior

Washington

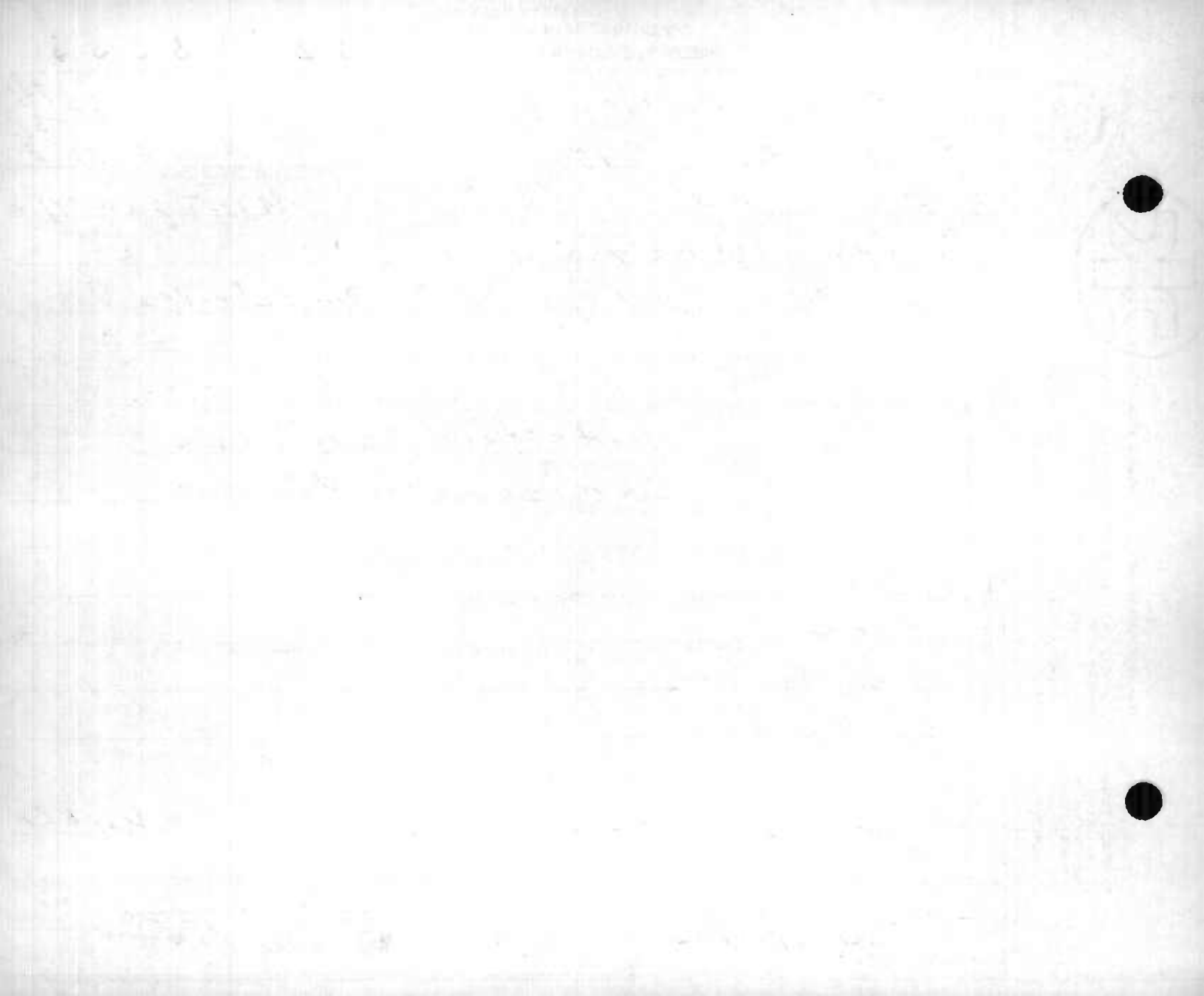
U.S. National Museum, Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 13335							
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				MONTH DAY YEAR				2b. HOUR			
Elsie						Delcina Licovich						May 6 1982				545 PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				2d. HOUR							
F		131K		Feb 11 87		78 YRS.		MONTHS		DAYS		May 6 1982				545 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Barbados						West Indies						Montgomery MD.											
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Sil. Spr.						9111 Balmoral Dr.						Housewife				Home							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				9111 Balmoral Dr.							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																	
Charles Richards						Albertine Blackett																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS											
No						578-74-6172						Mrs. Shirley Kibunja Sil. Spr., Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Metastatic Carcinoma																							
1579																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) Carcinoma of Pancreas																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
None																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
						P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION											
												CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED											
John J. Rogers M.D.						Dep.						May 6 82											
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY											
Removal						May 9 1982						St. Michael, Barbados											
24. FUNERAL DIRECTOR NAME						25a. DATE RECEIVED BY REGISTRAR						25b. REGISTRAR'S SIGNATURE											
John J. Rogers 7400 Georgia Ave, NW						May 12 1982																	
McGuire Fun. Ser., Inc.						Washington, DC																	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 3 3 3 6
REG. NO.1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CHIN-Lung		FIRST MIDDLE LAST Lien		2a DATE OF DEATH MONTH DAY YEAR 5 25 82		2b HOUR 4:20AM	
3 SEX Male		4 RACE Oriental		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 56	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Taiwan		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b KIND OF BUSINESS OR INDUSTRY Merchant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Mont.		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Suai Chih Lien		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chuen Lien		13e STREET ADDRESS 14246 Briarwood Terrace			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 80 3185		17 INFORMANT ADDRESS Kwei Mei S. Lien (Wife) Same as above			
18 CAUSE OF DEATH Enter only one cause per line for a), b), and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma - Lung DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Hemoptysis DUE TO, OR AS A CONSEQUENCE OF: (c) Emaciation + Dehydration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1629							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-16 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from 5-16 1982 to 5-25 1982 , that I (we) last saw the deceased alive on 5-25 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maneym		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.G. Maneym		22e. ADDRESS 17904 Georgia Ave Olney Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/30/82		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Kistler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SHEN S E YAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 3 3 3 7 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST RICHARD WESLEY LOGAN				2a. DATE OF DEATH MONTH DAY YEAR MAY 07 1982		2b. HOUR 0230 A M	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 14, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Naval Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. STATE MARYLAND		13b. CITY OR TOWN PRINCE GEO.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7224 OLIVER STREET			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK JACK LOGAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES - Navy		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OF -ATRS) 1928-1954		17. INFORMANT RICHARD LOGAN		105 GARDEN DRIVE ANNAPOLIS, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 WIDELY DISSEMINATED SMALL CELL CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 06 MAY 19 82 to 07 MAY 19 82, that (I) (we) lost saw the deceased alive on 07 MAY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. S. Gurney LT MC MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. GURNEY, LT, MC, USNR				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md.				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 11 1982					

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

1821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 1 3 3 3 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eliza beth C. Long						2a. DATE OF DEATH MONTH DAY YEAR 5-7-82				2b. HOUR 5:40 P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone					
13a. STATE MD						13b. CITY OR TOWN Bowie		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 15712 Pinecroft Lan.			
14. FATHER'S NAME FIRST MIDDLE LAST Elmond Emmitt Bass				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Jacob									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 204-30-0921		17. INFORMANT ADDRESS Robert E. Long, 15712 Pinecroft La., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer (oat cell) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Esophageal obstruction													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 4/22 , 19 82 to 5/7 , 19 82 , that (1) <input checked="" type="checkbox"/> we last saw the deceased alive on 5/7 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) did not view the body after death.													
22b. SIGNATURE Peter Sherer MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/9/82			
22d. PHYSICIAN'S NAME, (TYPE OR PRINT) PETER SHERER				22e. ADDRESS 1109 Spring St. Silver Spring MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/11/1982		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Maryland					
24. FUNERAL DIRECTOR NAME Beall Funeral Home						24a. ADDRESS 16000 Annapolis Rd., Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE David O. ...			

Blank lined paper with two punch holes on the right side. Faint, illegible markings and bleed-through from the reverse side are visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8213339			
1. DECEASED NAME (TYPE OR PRINT) Albert Jackson Lovell				2a. DATE OF DEATH MONTH DAY YEAR 5-5-82			
3. SEX Male				2b. HOUR 4:40 M			
4. RACE White C		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 08		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brook Grove Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY N.O.L.	
13a. STATE Maryland		13b. CITY OR TOWN Laurel		13c. STREET ADDRESS 1129 12th Street		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel W. Lovell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winnie M Seal		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Tedford C. Lovell		17. ADDRESS 1129 12th Street Laurel Md 20707			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4029 MONTHS			
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive CardioVascular Disease				YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized ARTERIOSCLEROSIS				YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC RENAL FAILURE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 17, 1980 to MAY 5, 1982 , that (I) (we) last saw the deceased alive on MAY 5, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cezar A. Lopez		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 5, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CEZAR A. LOPEZ, MD		22e. ADDRESS 18111 PRINCE Phillip Dr. OLNEY, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Maryland	
24. FUNERAL DIRECTOR Black Laurel Funeral Home Inc.				25a. DATE RECEIVED BY REGISTRAR MAY 6 1982		25b. SIGNATURE Francis San Martin	
7601 Sandy Spring Rd. Laurel Md. 20707							

3 2 1 3

2 2

2 2 2 2

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

1 1 1 1 1 1 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be verified and signed by the medical examiner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		13340			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		13340			
Julia Irene Lusciandrello		May 4, 1982		4:25		a.m.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	White	May 22, 1925	56	YRS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
New Jersey	USA		Montgomery County, MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	Clinical Center (NIH)		Housewife		Own Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS					
New Jersey		Bergen		Rochele Park		9 Harvey Ave. 07662			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Vito nmnm Gianpetruzzini		Mary nmnm Gianpetruzzini							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		None		146-14-3397		Charles Lusciandrello Rochele, Park. M. J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Sepsis								2 weeks	
1830 DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure								2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) Ovarian Carcinoma								1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from Feb. 21, 19 82, to May 4, 19 82, that (X) (we) last saw the deceased alive on May 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
				4 May 82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
CARL A. PATOW MD		National Institutes of Health Clinical Center, Bethesda, Md, 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		5-8-1982		St. Marys Cemetery		Saddle Brook, New Jersey			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. W. Chambers Co., 8655 Georgia Ave, Sil. Spg.		MAY 7 1982		Frances Jan Nathan					

OWNERS

10000000

10000000

10000000
10000000
10000000

10000000
10000000
10000000

10000000
10000000
10000000

10000000
10000000
10000000

10000000
10000000
10000000

10000000

10000000

10000000
10000000
10000000

Items #18a-22a Film G569 7/8/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

2- DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 5-27-82

3- MONTH DAY YEAR 5-27-82

4- HOUR MIN 6:51A

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KANEESHA J. LYLES

2. SEX F 3. RACE Black 4. DATE OF BIRTH MONTH DAY YEAR 3 18 1981 5. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 1 YRS 04

6. IF UNDER 24 HRS. 7. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-27-82 19

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD

10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington Adventist Hospital

12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT 13. CITY OR TOWN OF DEATH Takoma

14. FATHER'S NAME FIRST MIDDLE LAST Henry Lyles 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belinda Blair

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No 17. SOCIAL SECURITY NO. N/A 18. INFORMANT ADDRESS Belinda Lyles 1058 RUTAN ST.

19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undetermined
79999
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Margaret McNeill M.D. Assistant MEDICAL EXAMINER TITLE (SPECIFY) DATE SIGNED 5-27-82

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

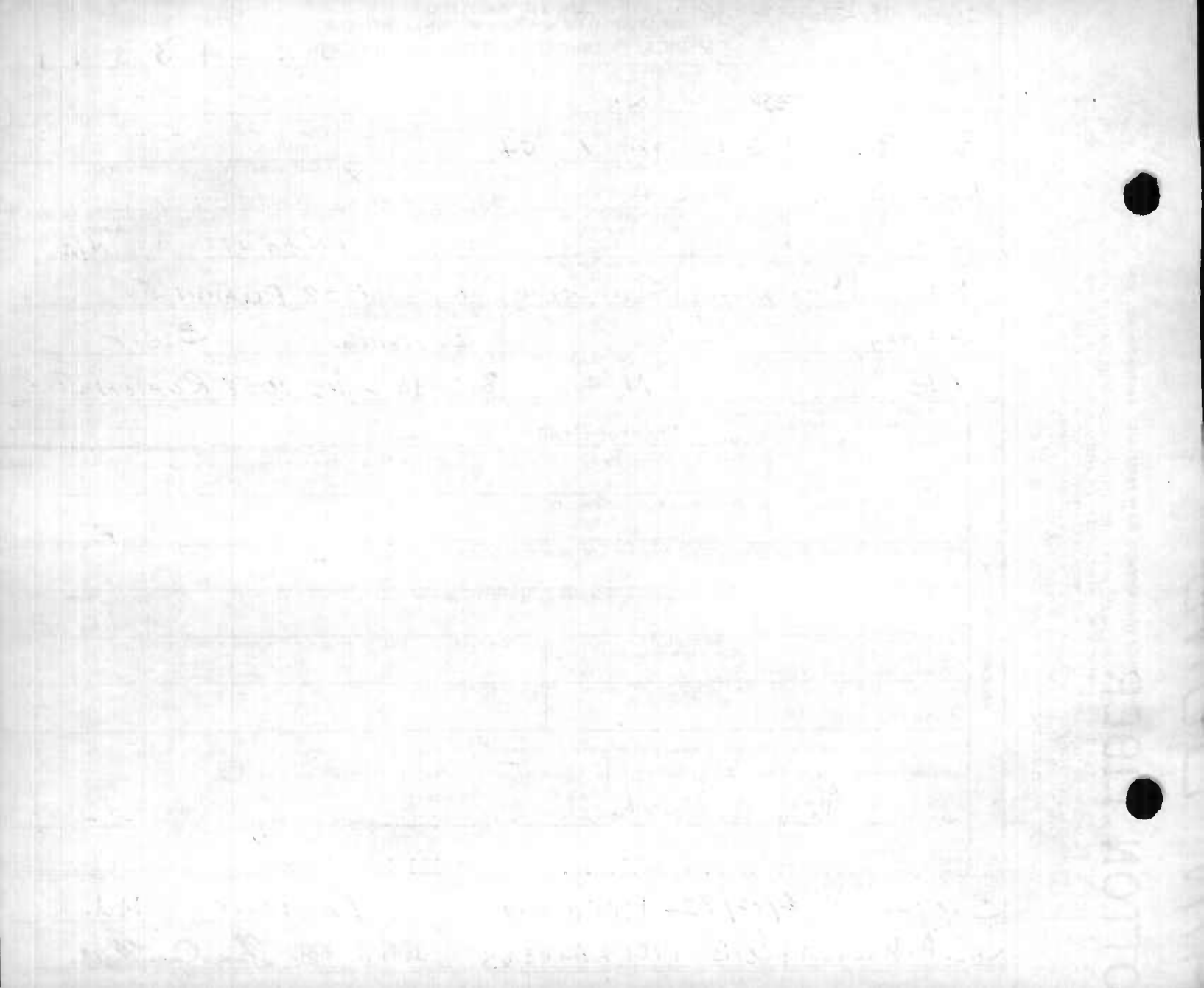
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 6/02/82 23c. NAME OF CEMETERY OR CREMATORY Harmony 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER Md.

24. FUNERAL DIRECTOR NAME ADDRESS JAS. A. MORTON & SONS 1701 LAURENS 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 25b. REGISTRAR'S SIGNATURE

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN FOUR HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 3 4 2									
1. DECEASED NAME (TYPE OR PRINT) <i>Etha Lynch</i>										2a. DATE KNOWN OF DEATH <i>5-22-1982</i>										2b. HOUR <i>3:57 AM</i>																			
3. SEX <i>F</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH <i>2 25 1928</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54 YRS.</i>		IF UNDER 1 YR. MONTHS <i>4 times</i>		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <i>5-22-1982</i>		7d. HOUR <i>3:57 AM</i>																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>Amer</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONT</i>				MD.																							
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dietary in St. Elizabeth's Hosp.</i>				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. STATE <i>Md.</i>				13b. COUNTY <i>PG.</i>				13c. CITY OR TOWN <i>Hyattsville</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>1962 Village Green Dr.</i>																							
14. FATHER'S NAME FIRST <i>Joseph</i> MIDDLE <i>-</i> LAST <i>Herbert</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Nellie</i> MIDDLE <i>-</i> LAST <i>Armstrong</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>								16b. SOCIAL SECURITY NO. <i>578-44-4111</i>				17. INFORMANT <i>SHARON WILLIAMS DAUGHTER 1520 VILLAGE GREEN DR. LANDOVER, MD</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) <i>Malnutrition</i>										<i>weeks</i>																													
1536 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																							
(b) <i>Multiple Organ failure from metastatic</i>										<i>Months</i>																													
DUE TO, OR AS A CONSEQUENCE OF																																							
(c) <i>Adenocarcinoma of right colon</i>										<i>2+ years</i>																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																							
<i>Surgery for relief of intestinal obstruction due to above</i>																																							
19a. DATE OF OPERATION <i>4-21-1982</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Recurrent adenocarcinoma of Right Colon</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <i>W.W. Eastman</i>				TITLE (SPECIFY) _____				DATE SIGNED _____																															
EXAMINER'S NAME (TYPE OR PRINT) _____				ADDRESS _____																																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>5/27/82</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i>																															
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, PG Maryland</i>																																							
24. FUNERAL DIRECTOR NAME <i>ALEXANDER S. POPE</i>				ADDRESS <i>2617 Pennsylvania Ave., S.E.D.C.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 24 1982</i>																															
25b. REGISTRAR'S SIGNATURE <i>James J. R. R. R.</i>																																							

BP

3402 DHMH-17
(VR A15 ME (5))
15M 2/80

RE QUALITY 0521 SETHUAM EMALITY WOMANO
CM, SEVOMAI

Items #10a-22a Film G569 7/29/82 r STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 4 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
Ann		K.		Macomber				5		1		1982	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	July 17, 31		50 YRS.		MONTHS DAYS		HOURS MIN.		5		2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Iowa		U.S.A.				Montgomery County,							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Germantown		19148 Aldenham Court											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Mont		Germantown		YES <input type="checkbox"/> NO <input type="checkbox"/>		19148 Aldenham Court					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
						480-32-2509							
16a. UNKN.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 4290 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia Dolan				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 5-2-82	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 5/4/82				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR MAY 10 1982				25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR	
FIRST William MIDDLE Anthony LAST Maio, Sr.		MAY 20, 1982		3		1		3 30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		White		NOV. 19 1996		85		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Italy		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Chevy Chase Nursing Center		Auditor		Pvt. Industry			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4601 N. Park Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No ---		577-07-8240		William A. Maio, Jr., Same address as #13.	
Pietro --- Maio		Maria --- Astore							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>stroke</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 19 <u>80</u> to <u>5-20</u> 19 <u>82</u> , that (b) (we) lost saw the deceased alive on <u>5-12</u> 19 <u>82</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>James Brodsky</u>		MD				5-20-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
James Brodsky MD		4701 Willard Ave. Chevy Chase, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/24/82		Mt. Olivet Cemetery		Washington, D.C.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, Inc.		MAY 24 1982		<u>James Brodsky</u>					
5130 Wisconsin Ave., NW, Washington, D.C. 20016									

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

13042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 3 4 5			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST . LAURA L. MANSFIELD				2a. DATE OF DEATH MONTH DAY YEAR May 13, 1982		2b. HOUR 2:55P. M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 14, 1889		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA 5215 Cedar Ln.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Own Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. STREET ADDRESS 6700 Belcrest Road	
14. FATHER'S NAME FIRST MIDDLE LAST Edward McGrunder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Capitola Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578-46-1683		17. INFORMANT ADDRESS Richard H. Mansfield, III 1725 N. Danville St. Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Depression							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-17-82 , to May 13, 1982 , that (I) (we) lost saw the deceased alive on 5-17-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William H. Killay M.D.				DEGREE M.D.		22c. DATE SIGNED 5-14-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Killay				22e. ADDRESS 8218 Wisconsin Ave Bethesda MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-17-82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Female	White	October 1, 1898	May 17, 1898	2:10P.
Maryland	U.S.A.	X	Homeowner	Gen Home
Maryland	J.C.	X	6700 Belmont Road	
Town	McGinnis	Capitol	Alison	
778-10-1002	Richard H. Henselfield, III	Arlington, VA.	1705 N. Nevada St.	



1. George Sons & Co. P.A. Baltimore, Md.
2-17-98 Ft. Lincoln Cemetery, Baltimore, Md.
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be notated.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 3 4 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>WILLIAM AGNES MARR</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>5-3-82</i>		2b. HOUR <i>800 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 12 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>69</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Misc.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Stonema Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN SUCH FACILITY, GIVE STREET ADDRESS) CITY STATE COUNTY <i>Thyland Md. Pe Geo</i>		13b. CITY OR TOWN <i>Stonema Park</i>		13c. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <i>6600 Westmoreland Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Glenn B. Puel</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agnes H. Jones</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-88-3026</i>		17. INFORMANT ADDRESS <i>ANDREW J. MARR, 6600 WESTMORELAND AVE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF Lung & METASTASIS</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 22</i> 19 <i>82</i> , to <i>May 3</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>May 3</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard A. Fitzgerald</i> M.D.				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5-3-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD A. FITZGERALD</i>				22e. ADDRESS <i>317 UNIVERSITY BLVD E, SILVER SPRING MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 6-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stonema Park</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Silver Spring Md. Montgomery Co. Md.</i>	
24. FUNERAL DIRECTOR <i>William Walters</i>				25. DATE REC'D BY REGISTRAR (MAY 17 1982) REGISTRAR'S SIGNATURE <i>James Van Natta</i>			

13310

13310

13310

13310

13310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE GRAHAM LAST MARKWOOD			2a. DATE OF DEATH MONTH DAY YEAR May 4, 1982		2b. HOUR 10:00 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 28 17		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF GREAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		
14. FATHER'S NAME FIRST MIDDLE LAST John S. Graham		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ward				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-18-0006		17. INFORMANT ADDRESS R. R. #1 Farah Dillow, Telford, Tenn. 37690		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4960 } DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease and COR PULMONALE (c) } DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/30 19 82 to 5/4 19 82 that (I) (we) last saw the deceased alive on 5/3 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE PENNY BISK		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Jonesboro, Tennessee		24. FUNERAL DIRECTOR NAME Ives Funeral Home 2847 Wilson Blvd., Arlington, VA 22201		25a. DATE REC'D. BY REGISTRAR MAY 11 1982		

1 3 3 4 1

4

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 1650M / 81
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 3 3 4 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HELEN T. MAZARELLA				2a. DATE OF DEATH MONTH DAY YEAR May 13, 1982		2b. HOUR 3:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1924		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS HOURS MIN. 57	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST F. Francis Sienuc		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Valerie Skrecko		13e. STREET ADDRESS 7501 Democracy Blvd., #B331			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO WW11 030-12-5483		17. INFORMANT ADDRESS Nicholas Mazarella (husband) (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer to bone and lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1749				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from April 28, 1982 , to May 13, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13, 1982 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE Jeffrey W. Clark		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY W. CLARK		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-17-82		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Georges Md	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave. ADDRESS S.S. Md.		25a. DATE REC'D. BY REGISTRAR MAY 20 1982		25b. REGISTRAR'S SIGNATURE James S. [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 2 1 3 3 4 9 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES E. MCDEVITT					2a. DATE OF DEATH MONTH DAY YEAR 5 29 82 2b. HOUR 8 P.M.					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 9 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10209 Tenbrook Dr.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Corun					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Whip					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-0943		17. INFORMANT ADDRESS Glen T. McDevitt Same as 13c						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA SIGMOID COLON 1533 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1978 to May 29, 1982, that (I) we last saw the deceased alive on 5/18/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.										
22b. SIGNATURE Robert J. Lindeman MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/29/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. LINDEMAN		22e. ADDRESS 10215 FERNWOOD RD BETHESDA AND								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY Alexandria Virginia				
24. FUNERAL DIRECTOR NAME Francis S. Collins Funeral Home 500 Univ. Blvd. W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE Name Jan [Signature]				

Release By De. Mayle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 3 5 0			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS Xavier MC DONOUGH				2a. DATE OF DEATH MONTH DAY YEAR May 05 82			2b. HOUR 11:06P ^M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17 1916		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Chevy Chase				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 9005 Springhill Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Francis X. McDonough				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 579 32 2247		17. INFORMANT Wife ADDRESS Jewel Rita McDonough Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 <u>58</u> to <u>Present</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>5/5</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN John B. Umhau MD				DEGREE MD		22c. DATE SIGNED 5/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau MD				22e. ADDRESS 8805 Conn. Ave., Chevy Chase			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Our Lady of Mt. Carmel Granville, NY		23d. LOCATION CITY OR TOWN COUNTY STATE Middle County MD.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAY 10 1982			
				25b. REGISTRAR'S SIGNATURE Thomas J. Foster			

1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 3 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Thomas Joseph McDonough				2a. DATE OF DEATH MONTH DAY YEAR 5 13 82			
3 SEX male				2b. HOUR 6 PM			
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 9 21 21		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turtle Creek Pa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PARSONS DRIVE 9237 E. XXXXXXXXXXXX		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Security Officer - NSA		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY montg. 13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9237 E. Parkhill Drive			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Thomas McDonough		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Elton Gribbin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) March 1942 August '62			
16b. SOCIAL SECURITY NO. 192-14-5132		17 INFORMANT ADDRESS Joan Lorraine McDonough (wife)		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pericardial Aneurysm 1550			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Defect in - Pericardium liver		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None							
19a. DATE OF OPERATION May 12 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF THE liver		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from February 19 82 to May 19 82 , that (I) (we) lost saw the deceased alive on May 12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Richard H. Knop				DEGREE MD		22c. DATE SIGNED 13 MAY 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD H. KNOP				22e. ADDRESS National Naval Med Center, Bethesda, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/19/82		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24 FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE James J. Martin	
500 UNIV. BLVD., W., SILVER SPRING, MARYLAND 20901							

1 2 3 4

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 5 2				
1. DECEASED NAME (TYPE OR PRINT) XXXXXXXXXX LESLIE J. McINTOSH							2a. DATE OF DEATH MONTH DAY YEAR May 26, 1982			2b. HOUR 320 P.M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 8, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1607 WINDHAM LANE					
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS W. McINTOSH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCINDA MAE REDDICK										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1941-1974				16b. SOCIAL SECURITY NO. 483-16-9622		17. INFORMANT JOANNE McINTOSH		ADDRESS SAME AS 13		WIFE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 5163 DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse Interstitial Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/26 , 19 82 , to 5/26 , 19 82 , that (I) (we) last saw the deceased alive on 5/26/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Jay Weiner MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/26/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD				22e. ADDRESS 4701 Randolph Rd										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/29/82		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JUN 1 1982								
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901														

1 2 3 4 5 6

THE UNIVERSITY OF CHICAGO
LIBRARY



95-187

82

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY



THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY



THE UNIVERSITY OF CHICAGO
LIBRARY



THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of our

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 5 3	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) ARTHUR GRAY McKAY					MAY 28, 1982		2:30 P.M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 23 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY USAF			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5100 DORSET AVE, CHEVY CHASE, MD				
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE							
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR GRAY McKAY, SR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ADA LEITCH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1934-1966		17. INFORMANT ADDRESS VIRGINIA S. McKAY, 5100 DORSET AVE., CHEVY CHASE, MD 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATIC ADENOCARCINOMA, DISSEMINATED 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from MAY 23, 1982, to MAY 28, 1982, that (we) lost saw the deceased alive on MAY 28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE 22c. DATE SIGNED 29 MAY 1982					22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEE, KENNETH M.						
22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. ADDRESS 5130 Wis. Av NW Washington, D. C. 20016					25a. DATE REG'D. BY REGISTRAR JUN 7 1982						

0 8 1 2 0

15

204-88-550

1

SP VAN 45

initial, not nite

Washington National

1-1-1

1-1-1

Don. Jackson on, etc.
JEO. J. V. H. Hamilton, . . . 1901

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 5 4	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) CHARLES Edwin McNAMARA						2a. DATE OF DEATH MONTH DAY YEAR MAY 17 82		2b. HOUR 8:50 PM			
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 24 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Surgeon		12b. KIND OF BUSINESS OR INDUSTRY Medicine			
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac			
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas McNamara						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norah Wholey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 679 60 3274		17. INFORMANT ADDRESS Dr. William A. McNamara see # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest. 4292 } DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which } Arteriosclerotic Cardiovascular gave rise to immediate } Disease. cause (a), stating the } underlying cause last } (c) _____ APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 7 years.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Alzheimer's Disease.											
19a. DATE OF OPERATION 5/17/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 75 5/17 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8218 Wisconsin Av., Bethesda, Maryland 20814							
22a. I certify that (I) (the hospital) attended the deceased from 5/17/82 to 5/17/82 , that (I) (we) last saw the deceased alive on 5/17/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I am) (did) (did not) see the body after death.											
22b. SIGNATURE J. Blaine Fitzgerald, MD						DEGREE MD		22c. DATE SIGNED 5/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, MD						22e. ADDRESS 8218 Wisconsin Av., Bethesda, Maryland 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 24, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Van Natten			

1881

May 11, 1881

1881

VIKING

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 5 5

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		7b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		11 A M	
Gertrude Meisels		5-26-82		11 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
F	W	MONTH DAY YEAR	90 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Austria		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9. BALTIMORE CITY OR COUNTY OF DEATH	
Silver Spring		Holy Cross Hospital		MONTGOMERY MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
ASHER		MORGENSTERN		LENA	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT CEREBRAL INFARCTION	
Milton Meisels		3906 Montrose Drive		8-9 DAYS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
4340		DUE TO, OR AS A CONSEQUENCE OF		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/3/82		Moshav Ber Tuvia, Israel	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels; 1170 Rockville Pike		MAY 27 1982		James J. Haden	

1950

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 AE (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 5 6

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
JEROME l. rwin MELTZER		5 21 19 82		9:45 a M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	White	8 5 1922	59 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
New York		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		Rt. 29, Rocky Gorge Reservoir		Photographer	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Montgomery		Sil. Spr.,	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Abraham G. Meltzer		Sara Farber		Yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
064-18-9414		Roslyn Meltzer		PART I DEATH WAS CAUSED BY:	
12001 Old. Col. Pike		12001 Old. Col. Pike		IMMEDIATE CAUSE (a) <u>Drowning complicating multiple injuries</u>	
12001 Old. Col. Pike		12001 Old. Col. Pike		DUE TO, OR AS A CONSEQUENCE OF	
12001 Old. Col. Pike		12001 Old. Col. Pike		(b) <u>water</u>	
12001 Old. Col. Pike		12001 Old. Col. Pike		DUE TO, OR AS A CONSEQUENCE OF	
12001 Old. Col. Pike		12001 Old. Col. Pike		(c) <u>water</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		6:30xx 5-21- 19 82		Driver of auto that drove off bridge into	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		water		Rt. 29, Rock Gorge Reservoir Montgomery Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		M.D. Assistant		5-22-82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/24/82		Mt. Lebanon Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE REC'D. BY REGISTRAR	
Warner E. Pumphrey, Inc.		P.O. Box 7428		MAY 25 1987	
25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	

BP

YAM 63 9201
James D. Jones

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13357

1. DECEASED NAME (TYPE OR PRINT) DONALD R MERCER										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 19 82				2b. HOUR 11:00 PM			
3. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR March 8, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 5 19 82		2d. HOUR 11:00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP								12a. USUAL OCCUPATION (TYPE OF WORK) Marine Information Specialist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
13a. STATE MD										13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 506 FLETCHER PLACE	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Mercer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Harris											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1957-1978		17. INFORMANT Nancy E. Mercer,				ADDRESS same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 4100 (b) CORONARY ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 2 YRS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																	
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M. 5 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED IN CHAIR									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 506 FLETCHER PL. Rockville Montgomery MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Francis C Mayle				TITLE (SPECIFY) Det				M.D. _____				MEDICAL EXAMINER		DATE SIGNED 5/24/82			
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle				ADDRESS 8200 Wisconsin Ave Bethesda MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 24, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia							
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA						ADDRESS Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Francis C Mayle							

1000 F. 100

1000 F. 100 1000 F. 100 1000 F. 100 1000 F. 100

1000 F. 100 1000 F. 100 1000 F. 100 1000 F. 100

1000 F. 100 1000 F. 100 1000 F. 100 1000 F. 100

1000 F. 100 1000 F. 100 1000 F. 100 1000 F. 100

1000 F. 100 1000 F. 100 1000 F. 100 1000 F. 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 5 8	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CATHERINE P. MILLER		3a. DATE OF DEATH MONTH DAY YEAR 5/29/82		2b. HOUR 5:00 PM			
3. SEX F		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 11 24 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALT. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Mont., MD.					
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERMAN WILSON HEALTH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 301 Russell Ave. (20877)			
14. FATHER'S NAME FIRST MIDDLE LAST George Loterer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Sidbrook		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 216-52-8055		17. INFORMANT Charles H. Cover, 303 E. Fayette St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(21202)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/9/81 19 to 5/29/82 19, that (I) (we) lost saw the deceased alive on 5/25/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Henry C. Scruggs MD		DEGREE		22c. DATE SIGNED 5/25/82				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRUGGS MD		22e. ADDRESS 5419 Cedar Lane Bethesda Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto., Md.					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, Inc.		ADDRESS 7401 Belair Rd. (21236)		DATE REC'D. BY REGISTRAR MAY 4 1982		25. REGISTRAR'S SIGNATURE Name					

BP

0 2 0 0 1 2 0

... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..

... ..
... ..
... ..
... ..

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 3 5 9																			
1. DECEASED NAME (TYPE OR PRINT) MARGARET C MILLER										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 13 1982										2b. HOUR 6:55 M																			
3. SEX Fe		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 10 5 94		6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 5 13 1982		2d. HOUR 5:26 M																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co., MD																											
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS WORKING LIFE) Representative Christmas Card				12b. KIND OF BUSINESS OR INDUSTRY																											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE MD										13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4757 Chevy Chase Dr													
14. FATHER'S NAME FIRST MIDDLE LAST Hubert W. Wells					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Colton					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 578-30-4685										17. INFORMANT ADDRESS Katharine W. Winfield, Sister, 1420 N. Franklin St. Wilmington, Del.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5621 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) SEPSIS - PERITONITIS DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED BOWEL - DIVERTICULOSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 24 hrs 48 hrs																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). INTERTROCHATERIC FRACTURE RT HIP																																							
19a. DATE OF OPERATION 5/1/82					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURE HIP RT										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 P.M. 5 5 1982					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUSE FELL IN HALLWAY OF HER APARTMENT																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME					21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4757 Chevy Chase Dr Chevy Chase Mount. MD																													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																													
ACTUAL SIGNATURE Francis C Mayle Jr					TITLE (SPECIFY) Dpt					M.D. 5/15/82					DATE SIGNED 20814																								
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle Jr					ADDRESS 8200 Wisconsin Ave Bethesda MD																																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE May 16, 1982					23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory, Alexandria, Virginia					23d. LOCATION CITY OR TOWN COUNTY STATE																								
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland										25a. DATE REC'D. BY REGISTRAR MAY 18 1982										25b. REGISTRAR'S SIGNATURE Francis C Mayle Jr																			

BP

TO THE HONORABLE
THE JUDICIAL BRANCH
OF THE STATE OF CALIFORNIA
AT THE CITY OF LOS ANGELES
COUNTY OF LOS ANGELES
STATE OF CALIFORNIA

IN RE: [Name]
[Address]
[City, State, Zip]
[Phone Number]
[Date]
[Signature]

BY: [Signature]
[Name]
[Title]
[Firm]
[Address]
[City, State, Zip]
[Phone Number]
[Date]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 6 0

REG NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pauline V. Moore			2a. DATE OF DEATH MONTH DAY YEAR May 11, 1982			2b. HOUR 1:20PM				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Howard		13c. CITY OR TOWN Highland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 108	
14. FATHER'S NAME FIRST MIDDLE LAST Millard W. Moore					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Dorsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Lula Moore (Mother) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary embolus 3429 DUE TO, OR AS A CONSEQUENCE OF: (b) Left Hemiparesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/10/82 4/1/82										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cholelithiasis and cholecystitis										
19a. DATE OF OPERATION 5/3/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cholecystitis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/1 , 19 82 , to 5/10 , 19 82 , that (I) (we) last saw the deceased alive on 5/10/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22. SIGNATURE K. C. Jonas					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. C. Jonas, M.D.					22e. ADDRESS 18111 Prince Phillip Dr., Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-15-82		23c. NAME OF CEMETERY OR CREMATORY Hopkins Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Highland, Howard, Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Washington Street Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1 2 3 4 5 6 7 8 9 10 11 12

STANDARD OF



Orig. death on old form, retyped and used orig. Dr's

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Sig. and cod, FilmG568 6/3/82 kam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 6 1	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret T. Morrissey				2a. DATE OF DEATH MONTH DAY YEAR May 29, 1982		2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8719 Burning Tree Rd., 20817				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Power Co. American Elec.			
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8719 Burning Tree Rd.			
14 FATHER'S NAME FIRST MIDDLE LAST Michael Morrissey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 081-07-6782		17 INFORMANT ADDRESS Bethesda, Md. Mrs. Helen Quinn, 8719 Burning Tree Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Cordine Arrest</u> DUE TO (b) <u>ASWO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral Dysmetria</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>82</u> , to <u>5/25</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/11</u> , 19 <u>82</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Walter Moore</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/25/82</u>					
22c. PHYSICIAN'S NAME (Type) W. TABOR MOORE				22d. ADDRESS 1145-15th ST NW Wash DC 20036							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1, 82		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Long Island City, N.Y.					
24 FUNERAL DIRECTOR NAME DeVol Funeral Home, Wash., D.C.				25a. DIRECTED BY REGISTRAR SIGNATURE JUN 3 1982 Frances Jean Nathan							

BP

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 6 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Madelyn		M.		Morrow				5-6-82					9:20 A.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		12 7 1896		85		MONTHS		DAYS		HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
W. Va.		USA				Montgomery						MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE CITY AND STATE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Wheaton		Randolph Hills Nursing Home		retired		cook							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1712 Grandin Avenue					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John		Murray		Mary		Bumgardner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
no		232-20-1498		Robert Q. Morrow		same as 13e							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia		1 day											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b)											
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Gastrointestinal Hemorrhage											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
saw the deceased alive on 4-12-82 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		Patricia D. Kellogg						5/6/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Patricia D. Kellogg, M.D.		809 Viers Mill Rd. Rockville MD 20851											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Cremation		5/7/82		Metropolitan Crematory		Alexandria, Virginia							
24 FUNERAL DIRECTOR'S NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wheeler Funeral Home, Inc.		1331 Rockville Pike Rockville, Md. 20852		MAY 10 1982									

Horror

M.

Wesley

92

1931 7 11

White

Female

Montgomery

XX

USA

M. Va.

cook

resting

Angelika Hilja Wurain Rome

Wheaton

1931 Franklin Avenue

XX

Rockville

Montgomery

Maryland

Montgomery

XX

Rockville

John

325-20-1498 Robert D. Horror name as 130

no

1931

Rockville

x

April 18 1931

1931

Rockville

Oranston V 1/2 Metropolitan Cemetery Alexandria, Virginia

Rock Hill Farm and Home, Inc.

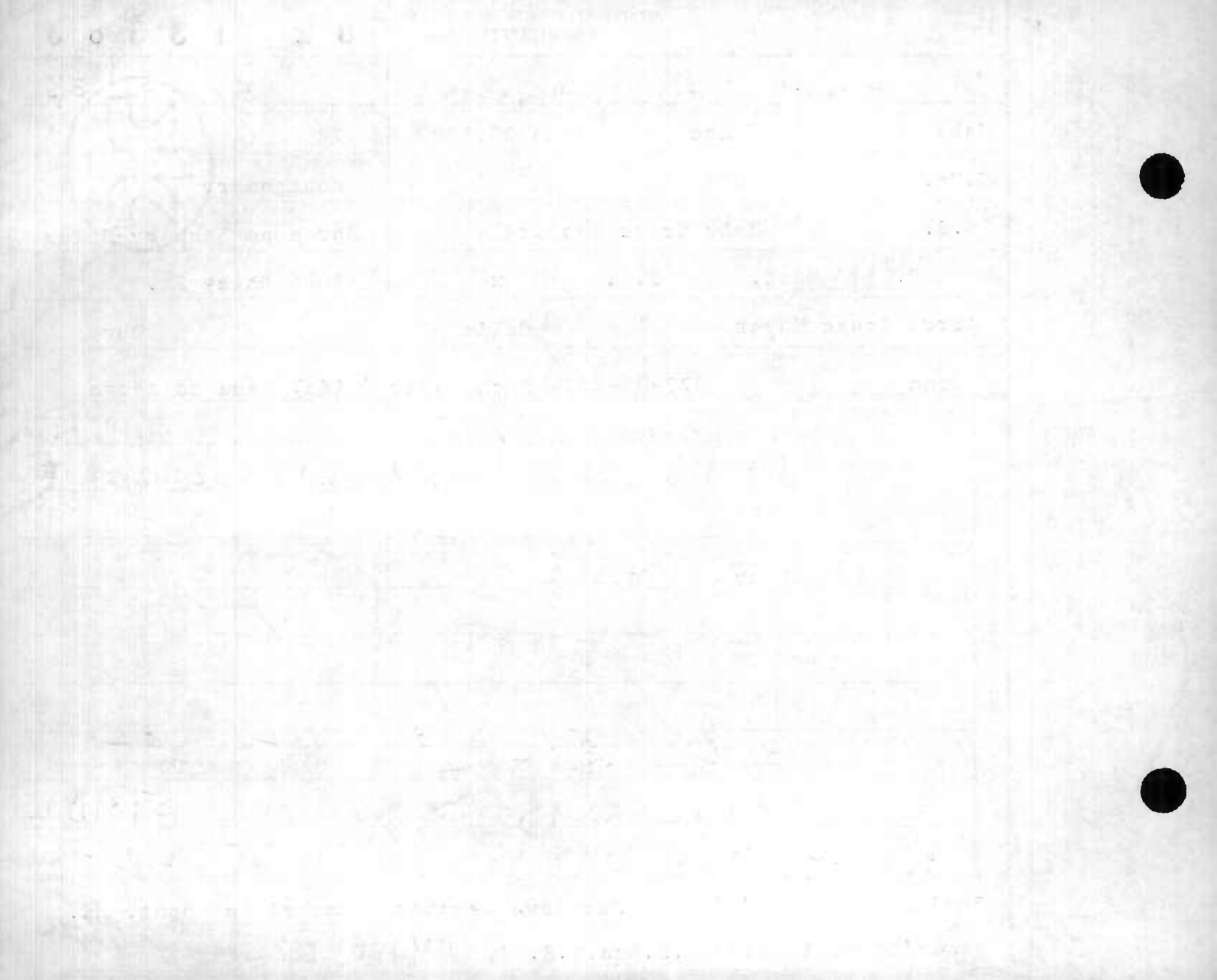
1931 Rockville like Rockville, Md. 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 3 6 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hobart H Moyer				MONTH DAY YEAR 5 - 2 - 82		2b. HOUR 3 ¹⁰ P ^M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bergmann Laundry		12b. KIND OF BUSINESS OR INDUSTRY Sales	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13e. STREET ADDRESS 13006 Daley St.	
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Issac Moyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Ours			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None				16b. SOCIAL SECURITY NO. 577-09-2536		17. INFORMANT ADDRESS Ruth Moyer (Wife) Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia Sepsis Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/2/82 1:00 AM 5/2/82 4:00 PM 3:10 PM							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Stroke</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>82</u> , to <u>5/2</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Penny Bisk MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY BISK MD				22e. ADDRESS 8630 FENTON ST SWEET SP. MD			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/5/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE <u>Francis J. ...</u>	



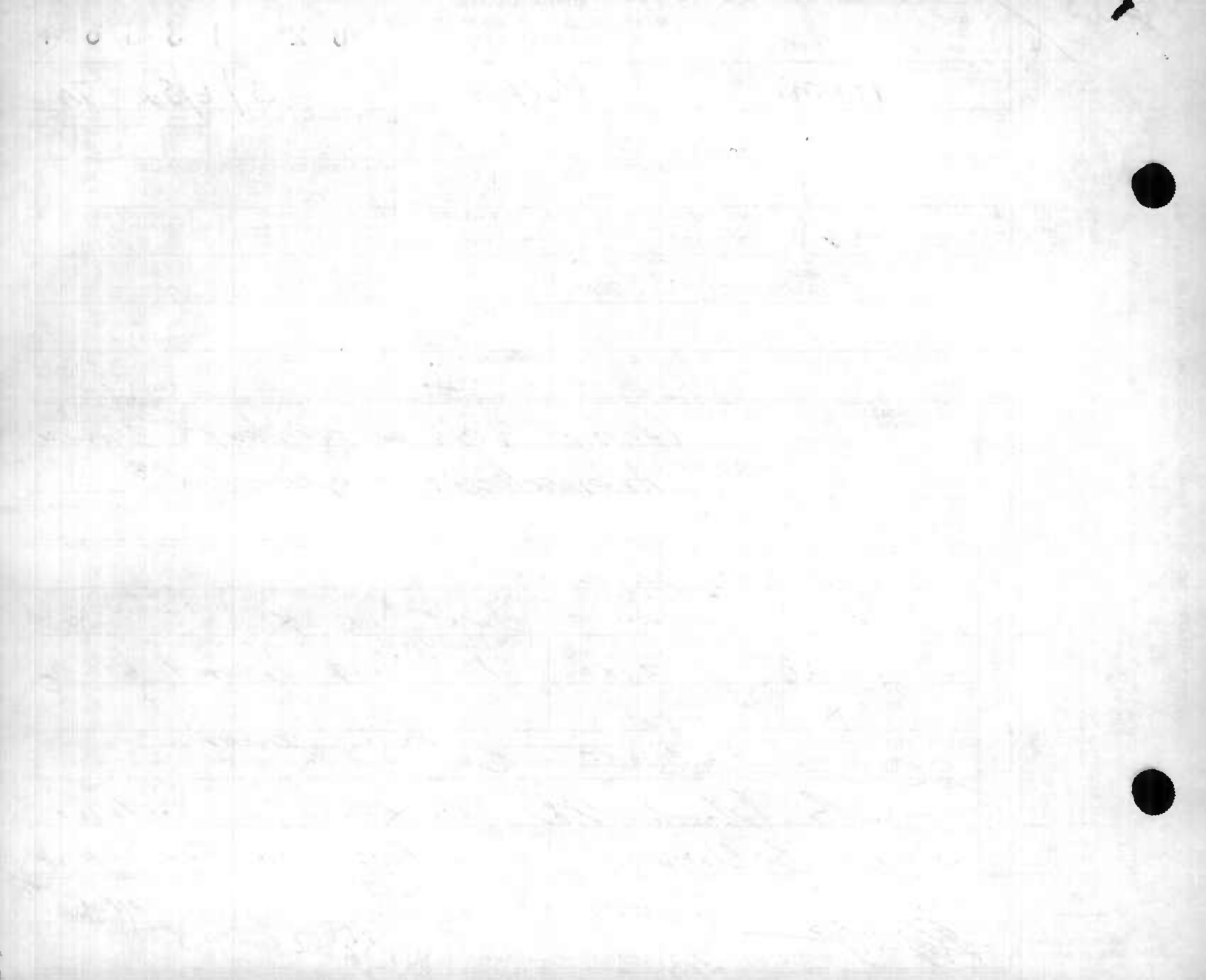
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 3 3 6 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) 1st NAME		FIRST P.		MIDDLE P.		LAST MURPHY		2a. DATE OF DEATH MONTH DAY YEAR 5/6/82		2b. HOUR 7A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 18 1899		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7d. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY G.P.O.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 815 Richmond Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST John B. Palmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie A. Morris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT H. 11600 Sourwood Lane				ADDRESS Daniel L. Murphy Reston, Virginia			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerosis - general DUE TO, OR AS A CONSEQUENCE OF (c) 18 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of breast											
19a. DATE OF OPERATION 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Breast				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/82 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall with Fractured Rt. leg							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Carriage		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Carriage							
22a. I certify that (I) (this hospital) attended the deceased from 19 05 , to present 19 82 , that (I) (we) lost saw the deceased alive on May 3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Umk...				DEGREE MD				22c. DATE SIGNED 5/6/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umk...				22e. ADDRESS 8805 Conn. Ave. Chevy Chase							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/1982		23c. NAME OF CEMETERY OR CREMATORY Colesville Meth. Ch. Collesville, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE Collesville, Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Sil. Spr., Md.				ADDRESS P.O. Box 7428				25a. DATE REC'D. BY REGISTRAR MAY 12 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 6 5		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 5 1 82 150 M							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST May FRANCES MURPHY					2b. DATE OF DEATH MONTH DAY YEAR 5 1 82 150 M							
3. SEX Female		4. RACE Cause		5. DATE OF BIRTH MONTH DAY YEAR JUNE 26, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD MURPHY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET SULLIVAN		13e. STREET ADDRESS 1087 LARKSPUR TERRACE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 579-68-1814		17. INFORMANT MARY M. BURT		ADDRESS SAME AS 13		DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
4860 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: arteriosclerosis												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (with hospital) attended the deceased from 5-1-82, to 5-1-82, that (s/he) last saw the deceased alive on 5-1-82, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) could not view the body after death, view the body after death.)												
22b. SIGNATURE John S. Saia / SA				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/1/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. SAIA				22e. ADDRESS Jones 809 Viers Mill Rd Rock								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/4/82		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAY 6 1982				25b. REGISTRAR'S SIGNATURE				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												

0 0 0 0 0

21.08.17

Handwritten notes, possibly a list or description.

Handwritten notes, possibly a list or description.



Handwritten notes, possibly a list or description.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

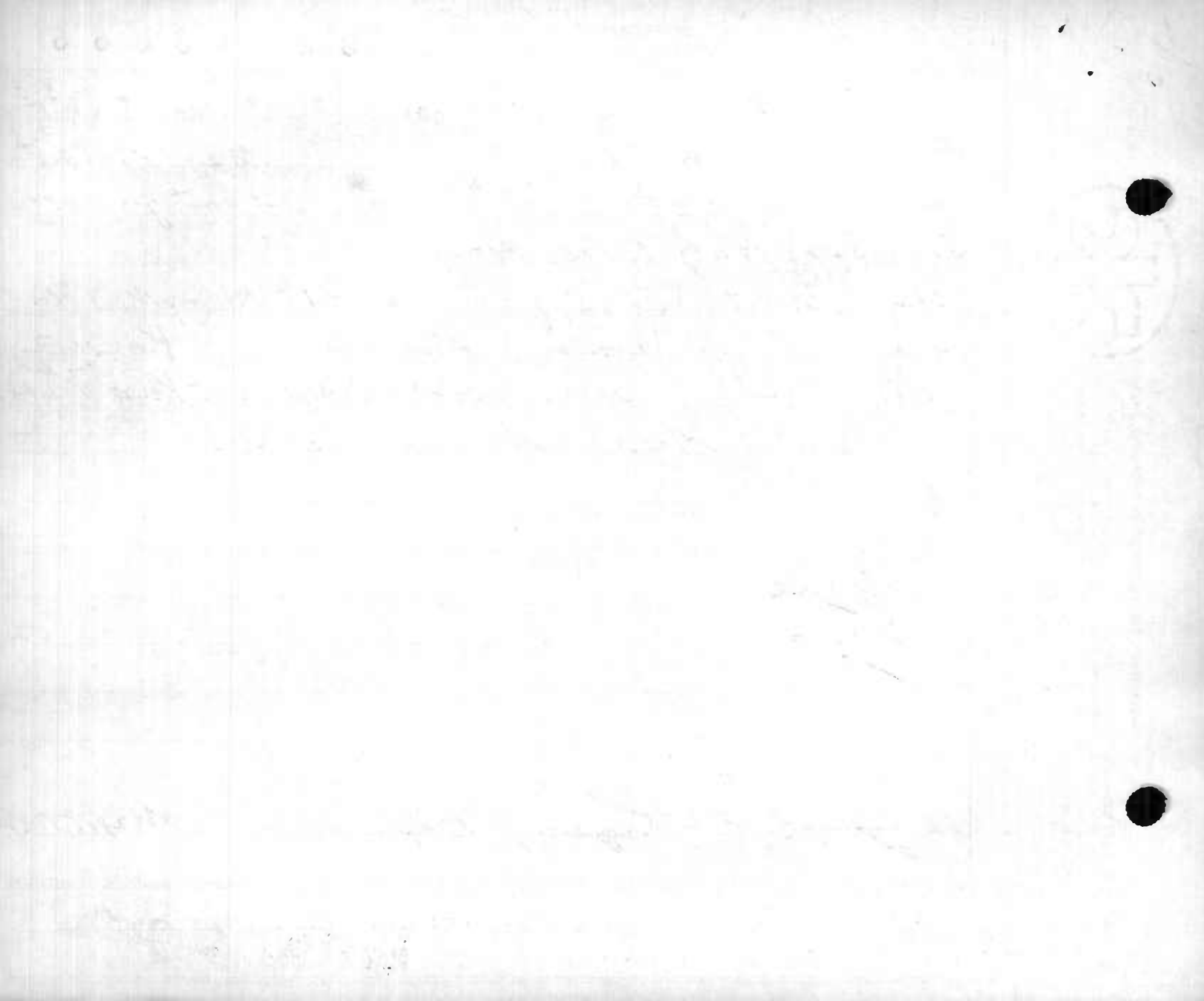
DMHM-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 3 6 6

1. DECEASED NAME (TYPE OR PRINT) <i>Florence R. Naham</i>		2a. DATE KNOWN OF DEATH ESTIMATED <i>May 16, 1982</i>		2b. HOUR <i>3:55</i>	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 6 1863</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>19 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		10. CITY OR TOWN OF DEATH <i>Pt. Spg. Holy Cross Hosp.</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----		13. STREET ADDRESS <i>12215 Kemp Mill Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JACK VOGEL</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LILLIAN KARMEL</i>		16. SOCIAL SECURITY NO. <i>UNK.</i>	
17. INFORMANT NAME ADDRESS <i>SIDNEY S. NAHAM 12215 Kemp Mill Rd.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> 4291 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) <i>Doc</i>		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED <i>May 18, 1982</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-18-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Mem. Gardens</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Danzansky-Goldberg Chapels; 1170 Rockville</i>		25a. DATE REC'D. BY REGISTRAR <i>May 24 1982</i>		25b. REGISTRAR <i>[Signature]</i>	
26. LOCATION CITY OR TOWN COUNTY STATE <i>Olney, Maryland</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 6 7			
1. DECEASED NAME (TYPE OR PRINT) Pearl O. VALLEY										2a. DATE OF DEATH MONTH DAY YEAR 5/ MAY 31/ 82		2b. HOUR 10¹⁵ P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1801 Gayfield Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST David Woolard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Balderson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 577 10 9117A		17. INFORMANT Same as above (June Hamm) Adm. of Estate)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4341 IMMEDIATE CAUSE (a) Congestive HEART Failure DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED AGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple Cerebrovascular Emboli													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 1980 19 9 MAY 19 82 , to 31 MAY 19 82 , that (1) we last saw the deceased alive on 9 MAY 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did (1) did not view the body after death.													
22b. SIGNATURE Carol Jean Smith, MD				DEGREE MD				22c. DATE SIGNED 31 MAY 82		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL JEAN SMITH, M.D.				22e. ADDRESS 15612 Good Hope Rd. Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood PG Md.				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi				ADDRESS 11800 N.H. Ave S.S. Md.				25a. DATE REC'D. BY REGISTRAR JUN 3 1982					
								25b. REGISTRAR'S SIGNATURE Charles Jan Thorton					

RECEIVED BY THE
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE

01 23/15

RECEIVED BY THE
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE



RECEIVED BY THE
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 8 2 1 3 3 6 8					
1. DECEASED NAME (TYPE OR PRINT) Freemont W. NELSON					2a. DATE OF DEATH MONTH DAY YEAR May 8, 1982			2b. HOUR 9:30P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 219 Oakton Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exhibit Specialist		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Montgomery					13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 219 Oakton Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Asa Nelson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Dauler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2 & Korea		17. INFORMANT Leah June Nelson, Item 13		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated carcinoma of the bladder 1889 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from May 27, 1979, to May 8, 1982, that (1) (we) lost saw the deceased alive on May 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cheryl Winchell MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 9, 1982				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cheryl Winchell, M.D.				22e. ADDRESS 19241 Montgomery Village Ave., Gaithersburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Church of Brethren		23d. LOCATION CITY OR TOWN COUNTY STATE Eastville, Penna. Md.				
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.				ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE		

541

2. On 10/10/08

• 1000 1

17

PC-

500

• • •

• 2024

CONCLUSION

• 38 •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Item 18 Film 571 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1- STATE REGISTRAR 9-3-82 cn MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13369	
1. DECEASED NAME (TYPE OR PRINT) Richard Ernest Neuenhahn						2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH 5 DAY 11 YEAR 1982		2b. HOUR M			
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH Jan. DAY 28 YEAR 1937	6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	7c. DATE PRONOUNCED DEAD MONTH 5 DAY 11 YEAR 1982		7d. HOUR 9:47 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brickmason		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland		13b. CITY OR TOWN Prince Geo. Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2500 Queens Chapel Road					
14. FATHER'S NAME FIRST William MIDDLE E. LAST Neuenhahn				15. MOTHER'S MAIDEN NAME FIRST Daisy MIDDLE M. LAST Newkirk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 48 6536		17. INFORMANT ADDRESS Daisy M. Neuenhahn Same as #13 (Mother)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy Bleeding Diathesis of Unknown DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Etiology DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Voussite De Krell		TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5/12/82					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 14 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

DHM-17
(VR A15 ME (5))
15M 2/80

Francis Joseph's home, 1.1.
Gastaville, Maryland

Smith 247725 St. Lincoln Cemetery 7.7. Maryland

378 48 8758 Daisy M. Neuenhahn (see in 215 (Hofen))

William F. Neuenhahn Daisy M. Neuenhahn

anyland since 1900. Gastaville x 21700 (see in 215 (Hofen))

Richmond Construction

Residing in 1.1.

Jan. 22, 1917

Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 3 7 0									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Zona		V				Newhouse		May 3 1982		10:30 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		June 30 1900		81 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
WV		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1905 Winnexburg Court Apt. 102			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
George W. Shank				Susan Peters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				236-14-6024		Rockville, Md. N. David Newhouse, 12117 Porttree Drive,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)										1749	
DUE TO, OR AS A CONSEQUENCE OF										Commons of Breast metastases	
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
Chronic obstructive pulmonary disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN		COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 3/10 1982 to 5/3 1982, that (2) (we) most saw the deceased alive on 5/3 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
MYRON L. LENKIN						5/3/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
MYRON L. LENKIN		8329 Shorefield Rd Wheaton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE			
Burial		5/6/82		Indian Mound Cemetery		Romney		Hampshire WV			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS		MAY 10 1982		Name John Newhouse							
Shaffer Funeral Home, Romney, WV											

BP



Handwritten text, possibly a signature or title, centered on the page.

Handwritten notes or signatures at the bottom of the page, including the word "BUTTER" and "BUTTER" written vertically.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 3 7 1	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HUNG PHI NGUYEN						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-28-82		2b. HOUR M 4:PM	
3 SEX Male		4 RACE Vietnamese		5. DATE OF BIRTH MONTH DAY YEAR 2-3-42		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 40		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-28-82 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Vietnam		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) IBM Bldg. Fernwood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee		12b. KIND OF BUSINESS OR INDUSTRY I.B.M.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1000 Good Hope Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Nhien Van Nguyen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Huyen Thi Do				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no n/a			
16b. SOCIAL SECURITY NO. 586-40-8019				17. INFORMANT ADDRESS 1000 Good Hope Dr Phuong Thi Dang-wife-Silver Sp, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE Shotgun wound of back of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR P.M. 5-28-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) IBM bldg		21f. LOCATION STREET CITY OR TOWN STATE Fernwood Road Bethesda, Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard				M.D. Assistant				DATE SIGNED 5-29-82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Colonial Funeral Home-Falls Church, Va.						25a. DATE REC'D. BY REGISTRAR JUN 7 1982		25b. REGISTRAR'S SIGNATURE			

BP

Main
 2-3-42
 U.S.A.
 Employee
 I.D.N.

1000 Good Road Drive
 Silver Spring
 Montgomery
 1000 Good Road Drive
 Silver Spring
 Montgomery
 1000 Good Road Drive
 Silver Spring
 Montgomery

Colonial Funeral Home-Tale Church, Va.
 Arlington, Virginia
 1-1-52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 3 7 2	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Owen		MIDDLE Smoot		LAST Nibley		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE		White		1 30 28		54 YRS.		5 10 1982		A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Washington, D.C.		U.S.A.		WIDOWED		DIVORCED		MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		5209 WEHAWKEN RD		NEGOTIATOR		U.S. Customs					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		MONTGOMERY		BETHESDA		YES		5209 WEHAWKEN RD			
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST	
Carlyle		---		---		Zella		---		Smoot	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		Korea; Viet Nam		578-34-3347		Elizabeth B. Nibley --		Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>ASPHYXIA</u>										ACUTE	
9530 } DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>HANGING</u>										ACUTE	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>DEPRESSION</u>										15 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
EALYON 5 10 1981				HUNG IN GARAGE							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
HOME				5209 WEHAWKEN RD BETHESDA MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Francis C Mayle				M.D.				5/18/82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Francis C Mayle				8200 Wisconsin Ave Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		STATE	
Burial		5/13/82		Arlington Nat'l. Cem.		Ft. Myer, Virginia					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Jos. Gawler's Sons, Inc.						MAY 14 1982		James J. Nathan			
5130 Wisconsin Avenue, N.W.-Washington, D.C.											

VOID

NOTE

NOTE

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 3 7 3								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL E. NORRIS, JR					2a. DATE OF DEATH MONTH DAY YEAR 5 1 82					2b. HOUR 6:10 A.M.
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 12 09		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
12. CITY OR TOWN OF DEATH SILVER SPRING		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hosp. 1500 Forest Glen Rd. S.S. Md				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		15. KIND OF BUSINESS OR INDUSTRY W.S.S.C.		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Norris, SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Howard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Nettie Norris (wife) Same As #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, left upper lobe</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Cardiomegaly; Pericarditis; Renal cortical infarcts; Gastrointestinal bleeding</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>82</u> to <u>5-1</u> 19 <u>82</u> that (we) last saw the deceased alive on <u>4-30</u> 19 <u>82</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.										
22b. SIGNATURE <u>Edmund J. Richards</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-1-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD Richards MD				22e. ADDRESS 10301 Georgia Ave, Silver Spring Md						
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial		23b. DATE 5-6-82		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Montg Md.				
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. N. A. B. S. A. Rockville, MD		25. DATE REC'D. BY REGISTRAR MAY 6 1982				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 7 4			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) ROBERT LEONARD NORTON						2a. DATE OF DEATH MONTH DAY YEAR 5 15 82				2b. HOUR 3:40^A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 12 01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.							
10. CITY OR TOWN OF DEATH Takoma Park,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter, Retired.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland.		13b. COUNTY P. Geo.		13c. CITY OR TOWN Takoma Park.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6410 4th Ave. Takoma Park.					
14. FATHER'S NAME FIRST MIDDLE LAST Robert Norton.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Norton.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 212-14-8786		17. INFORMANT ADDRESS A. Mildred J. Norton (Wife) 13 e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive Pulm Dis / Emphysema CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of Lung													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 21 , 19 82 , to May 15 , 19 82 , that (I) (we) lost saw the deceased alive on May 15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Habert				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/15/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial				23b. DATE May 18, 1982		23c. NAME OF CEMETERY OR CREMATORY George Washington Riggs Rd.		23d. LOCATION COUNTY STATE P. G. Co, Md.					
24. FUNERAL DIRECTOR Takoma Funeral Home.				25a. DATE REC'D BY REGISTRAR MAY 18 1982				25b. REC'D BY REGISTRAR					



Robert
212-14-8786 A. Mildred L. Norton (Wife) 13 e.
Norton. Norton.
Maryland. P. Geo. Takoma Park. +
6610 4th Ave. Takoma Park.
Takoma Park, Washington Adventist Hospital, Retired.
Maryland. U. S. A. Montpelier.

Burial May 18, 1983 George Washington Ridge Rd. P. O. Co., Md.
Takoma Funeral Home.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82		13375	
1. FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) DAVID J. NORWITZ						2a DATE OF DEATH MONTH DAY YEAR May 7, 1982				2b HOUR 4:30a.m.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher (Ret)		12b KIND OF BUSINESS OR INDUSTRY Meat Industry					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10820 Horde Street					
14 FATHER'S NAME FIRST MIDDLE LAST Morris Norwitz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Fradin									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-2300		17 INFORMANT ADDRESS Mary Norwitz; 10820 Horde St., SSpg., Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 48													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Chronic Lung Disease. Diabetes Mellitus</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>71</u> to <u>6 April</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>24 Apr</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <u>Ira N. Tublin</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-7-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA N. TUBLIN, M.D.						22e. ADDRESS 8830 Cameron St., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-9-82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike						25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

18012

1891

Received of the
Hon. Secy of the Interior
for the
Department of the Interior
the sum of \$100.00
for the
Department of the Interior

for the
Department of the Interior
the sum of \$100.00
for the
Department of the Interior

for the
Department of the Interior
the sum of \$100.00
for the
Department of the Interior

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 7 7			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES nmn OFFUTT						2a. DATE OF DEATH MONTH DAY YEAR May 28 82				2b. HOUR 1505			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12-25-20		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD						13b. COUNTY Montg		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BOOZE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE OFFUTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ruth Cross (sister) 906 Westmore Rockville							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a Cancer of buccal mucosa.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from May 22, 1982, to May 28, 1982, that (I) (we) last saw the deceased alive on May 28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Sidney J. Cohen				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/29/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen MD				22e. ADDRESS 121 Congressional Lane, Rockville									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6-4-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville MD					
24. FUNERAL DIRECTOR NAME George P. Snodden				24b. ADDRESS 246 N. WASH. Rockville, MD		25a. DATE REC'D. BY REGISTRAR JUN 4 1982		25b. REGISTRAR'S SIGNATURE Name Jan [Signature]					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 3 7 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Roberta M. Olds					2a. DATE OF DEATH MONTH DAY YEAR May 3 1982					2b. HOUR 12:15A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Asbury Village Wilgore Health Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY University				
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13821 Bauer Road		
14. FATHER'S NAME FIRST MIDDLE LAST William --- Olds					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline --- Pettijohn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---					16b. SOCIAL SECURITY NO. 579-44-7147		17. INFORMANT Jack Pettijohn					ADDRESS 13821 Bauer Road Rockville, Maryland	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular insufficiency (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 YRS 20 YRS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Chronic urinary tract infection													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/29/82 to 5/3/82 , that (I) (we) last saw the deceased alive on 4/29/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) last saw the body after death, state date and hour.)													
22b. SIGNATURE Nancy C. Scruggs DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/3/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hever C. Scruggs MD						22e. ADDRESS 5413 Cedar Lane Bethesda Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/8/1982		23c. NAME OF CEMETERY OR CREMATORY Custer Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Custer, South Dakota				
24. FUNERAL DIRECTOR NAME ADDRESS Jos. Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C.						25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE Shane J. Miller					

BP

250

not clear

3510

C

595/13/2

• 2011 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marion NMI O'Leary			2a. DATE OF DEATH MONTH 5 DAY 8 YEAR 82 2b. HOUR 12 ³⁰ A M	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 12 DAY 8 YEAR 96		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Henry MIDDLE Dorman LAST Dorman		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Hergenroether LAST Hergenroether		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO		17. INFORMANT Husband John A. O'Leary ADDRESS 14005 North Commons Way, Potomac, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Aug 1980 to May 7, 1982 , that (I) (we) last saw the deceased alive on May 7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Mary Fang, M.D.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/8/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary Fang, M.D.		22e. ADDRESS 11004 Roundtable Ct. Rockville, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1982	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery Middle Village, New York	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR MAY 12 1982 REGISTRAR SIGNATURE Francis J. [Signature]		

MEDICAL CERTIFICATION

18081 26

2.11.5

1.11.5

28

1.11.5

1.11.5

1.11.5

1.11.5

1.11.5

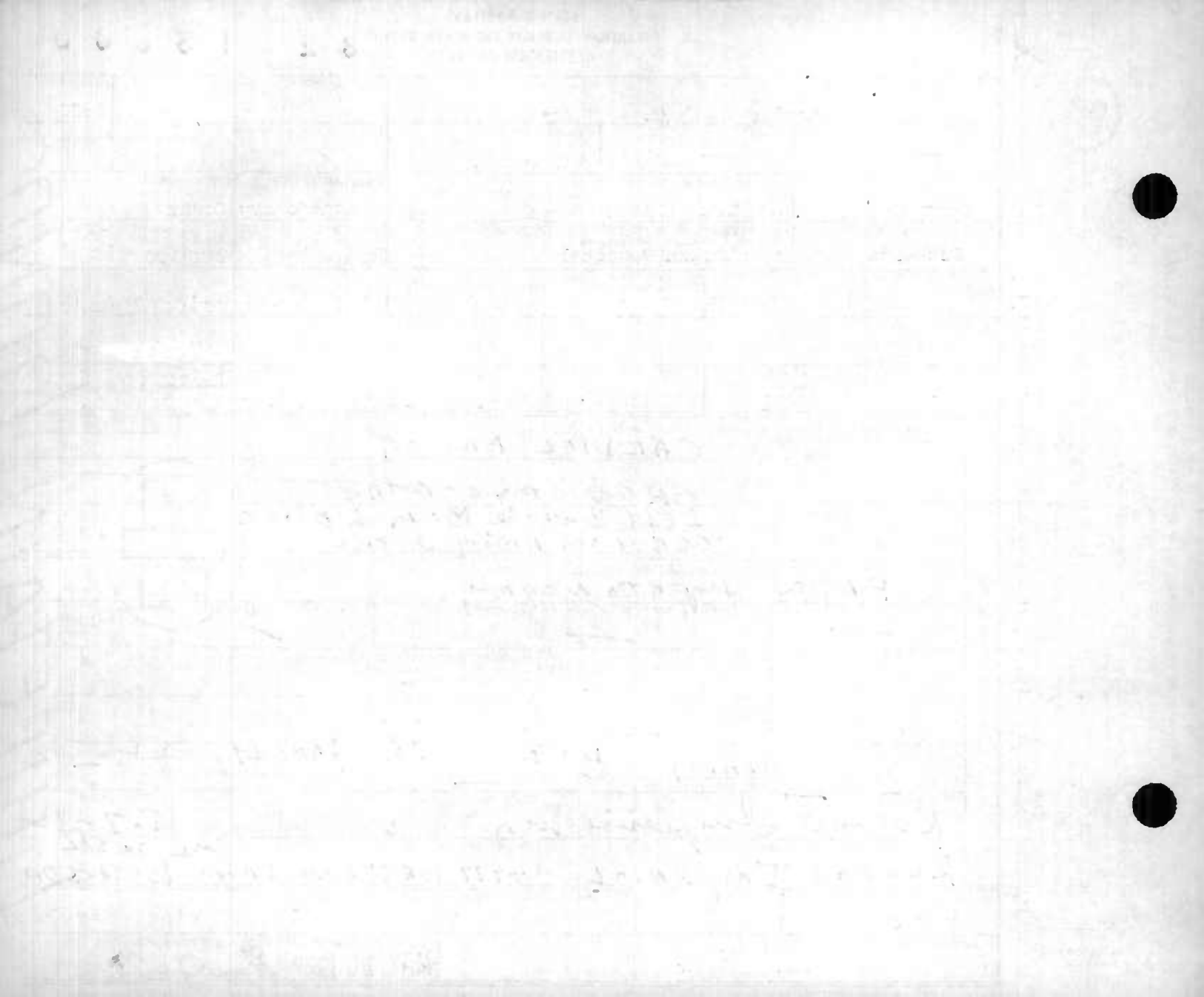
1.11.5

1.11.5

1.11.5

1.11.5

DHMH-16 30M 2/80
(VRA 15, 4)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Gary Robert Owens						DATE ESTIMATED			5 15 19 82			M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
male	white	Dec. 9, 1955	26 YRS.			5 15 19 82			7:42P						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Takoma Pk. Md.			U. S. A.						Montgomery County MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park			Washington Adventist Hospital			With Harry Diamond.Lab.									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Maryland			Montg.			Takoma Park.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7304 Garland Ave. Takoma Pk			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST						FIRST MIDDLE LAST									
Albert W. Owens.						Elaine Finnegan.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT						
Yes.						212-66-8256			1213 N. Belgrade Rd. S. S. M. Mrs. Elaine Natale. Mother.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Blunt injury to head and trunk															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				7:10PM 5/15 19 82				objects driver of motorcycle/lost control/fixed							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				roadway				1508 Erskine St, Takoma Park, PG Co., MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)						DATE SIGNED					
Virginia L. Dolan				M.D. Assistant MEDICAL EXAMINER						5/16/82					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Virginia L. Dolan, M.D.				111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				May 19, 1982				Parklawn				Silver Spring, Montg. Co.			
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Arthur Walter				MAY 19 1982											
254 Carroll St. N. W.															

• A • B • C • D • E • F • G • H • I • J • K • L • M • N • O • P • Q • R • S • T • U • V • W • X • Y • Z •

[illegible]

For. 313-66-8736 Mrs. Minnie Dale, Mother.

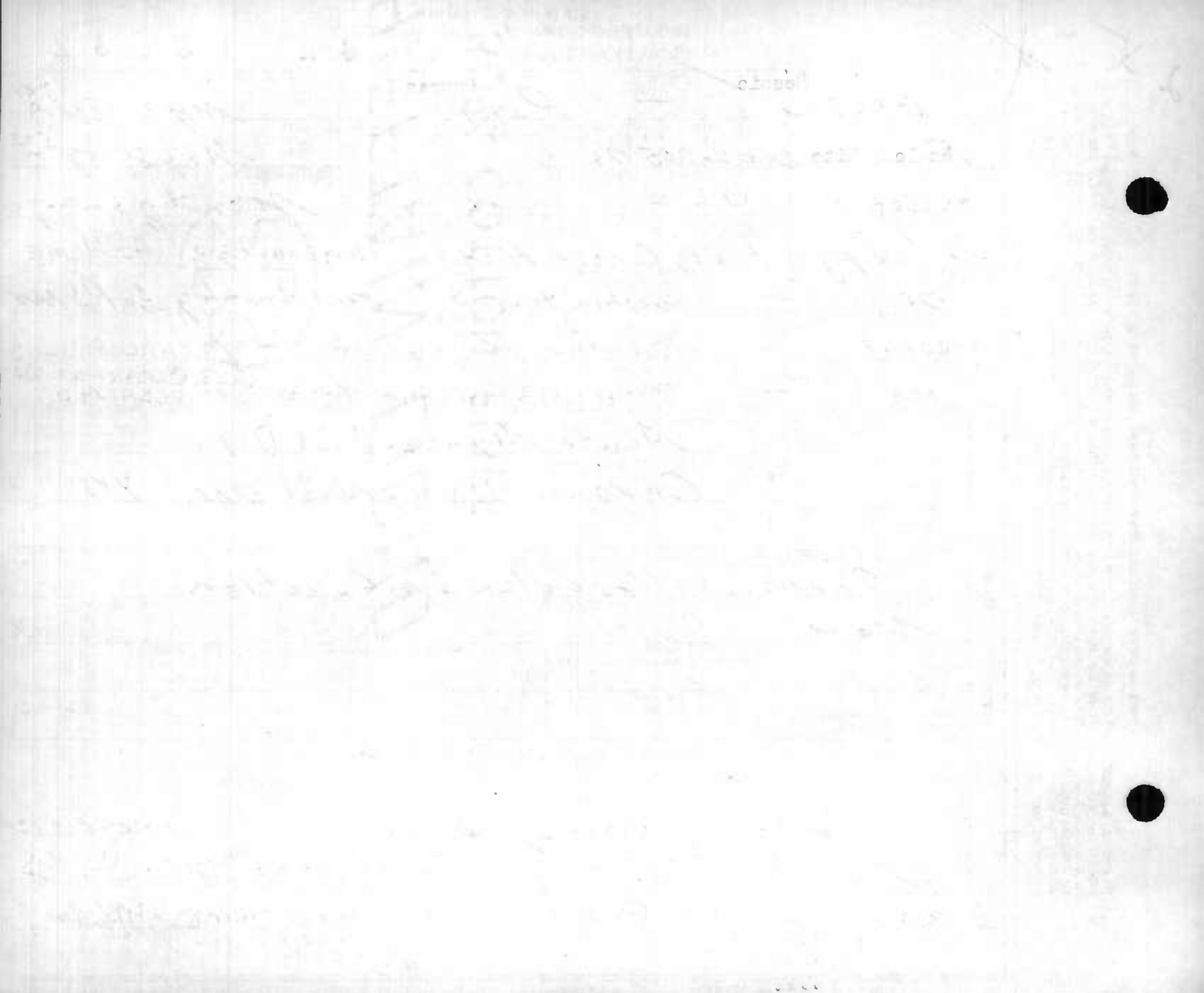
2-10-68

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13382	
1. DECEASED NAME (TYPE OR PRINT) Bessie			FIRST Bessie MIDDLE — LAST Pappas			2a. DATE KNOWN DEATH ESTIMATED May 8, 1982			2b. HOUR 10 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 02 DAY 20 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS — DAYS —		IF UNDER 24 HRS. HOURS — MIN —	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.		
10. CITY OR TOWN OF DEATH S. T. Spg.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		
13a. STATE DC.			13b. COUNTY —			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST GEORGE MIDDLE — LAST DOUNIS			15. MOTHER'S MAIDEN NAME FIRST ANGELIKI MIDDLE — LAST MICHALOPOULOS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 518-48-1813		
17. INFORMANT GEORGE PAPPAS			ADDRESS 253 CLEARWOOD RA. BETHESDA, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. 4291 (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) —			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cerebral Vascular Infarction											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) Dep.			MEDICAL EXAMINER			DATE SIGNED May 8, 1982		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS			ADDRESS SILVER SPRING, MONTG. CO., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/10/82			23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.			23d. LOCATION CITY OR TOWN BRENTWOOD COUNTY MD. STATE MD.		
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC. NAME ADDRESS 5130 WISCONSIN AVENUE, N.W.						25a. DATE REC'D. BY REGISTRAR MAY 12 1982					

WASHINGTON, D.C. 20016



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 3 3 8 3 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna L. PARKER		2a. DATE OF DEATH MONTH DAY YEAR 5/23/82		2b. HOUR 7A M	
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1-22-95		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 87 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md		13b. COUNTY Montgomery		13c. CITY OR TOWN Bensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2708 Calgary Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Harry ? Cranmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura ? Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-8697		17. INFORMANT ADDRESS Brother-in-Law James D. Parker Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary arrest</u> <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH T. med.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> , 19 <u>78</u> , to <u>5/23</u> , 19 <u>82</u> , that (I) <u>was</u> lost saw the deceased alive on <u>5/2</u> , 19 <u>82</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did not) view the body after death.									
22b. SIGNATURE <u>Sidney J. Cohen</u>				DEGREE MD				22c. DATE SIGNED 5/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, MD				22e. ADDRESS 121 Congressional Lane, Rockville					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	
26. FUNERAL HOME NAME 500 University Blvd., W. Silver Spring, Md.									

[Faint, illegible handwriting on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 3 8 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Bernardo</u> MIDDLE <u>—</u> LAST <u>Parronchi</u>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
3. SEX <u>Male</u>				4. RACE <u>White</u>			
5. DATE OF BIRTH MONTH DAY YEAR <u>Nov. 7, 1895</u>				6. AGE (IN YEARS (LAST BIRTHDAY)) <u>86</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD.			
10. CITY OR TOWN OF DEATH <u>Bethesda Md</u>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban hospital</u>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Cellist</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>			
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Bethesda</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>5225 Pooks Hill Road</u>			
14. FATHER'S NAME FIRST <u>Francesco</u> MIDDLE <u>—</u> LAST <u>Parronchi</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Carolina</u> MIDDLE <u>—</u> LAST <u>Colia</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES) <u>---</u>				16b. SOCIAL SECURITY NO. <u>110-03-5922</u>			
17. INFORMANT ADDRESS <u>Mildred Parronchi, Same address as #13.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respir. arrest</u>							<u>1 hr.</u>
3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Congestive Ht. Failure</u>							<u>6 weeks</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatic Heart Disease</u>							<u>50 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral Vascular occlusion, Hemiparesis & Aphasia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (myself) attended the deceased from <u>3/1/70</u> to <u>5/19/82</u> that (I) (we) last saw the deceased alive on <u>5/19/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.							
22b. SIGNATURE <u>Stephen N. Jones</u> DEGREE <u>ATTENDING PHYSICIAN</u> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/20/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen N. Jones</u>				22e. ADDRESS <u>809 Viers Mill Rd., Rockville, Md. 20851</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/22/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> NAME ADDRESS <u>5130 Wisconsin Ave., NW, Washington, D.C. 20016</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 24 1982</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

100 Wisconsin Ave., N.W., Washington, D.C. 20004
National Bureau of Investigation
Division of Criminal Investigation
Section of Identification
Washington, D.C. 20535
May 14 1968
Mr. J. Edgar Hoover
Director
Federal Bureau of Investigation
Washington, D.C. 20535
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.
Very truly yours,
[Signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DECEASED NAME CLARENCE CLARENCE E. PARSLEY		3. DATE OF DEATH May 27, 1982		4. HOUR 2215		5. REG. NO. 8 2 1 3 3 8 5	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 25, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 302 N. Frederick Ave. #7	
14. FATHER'S NAME FIRST MIDDLE LAST James Robert Parsley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle - Ray		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-07-5210		17. INFORMANT ADDRESS Sarah E. Parsley Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 4341 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Embolism mural</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intoxication</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 2 " yrs		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/27/82 to 5/27/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) want the body buried.		22b. SIGNATURE GOS G. WARD		22c. DATE SIGNED 5/27/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOS G. WARD		22e. ADDRESS 616 Rockwood, Bethesda, Md.		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda Mont. Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER		LAYTONSVILLE, MD.		20879					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 1 3 3 8 6				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Gaurav Patel					2a. DATE OF DEATH MONTH DAY YEAR 5 30 82 2b. HOUR 0020 AM				
3 SEX Male		4 RACE Indian		5 DATE OF BIRTH MONTH DAY YEAR 5 29 82		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 1 19		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) never employed		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. STREET ADDRESS 317 N. Summit Av Apt 3B			
14 FATHER'S NAME FIRST MIDDLE LAST Kanti Patel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bharti Patel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					16b. SOCIAL SECURITY NO. none		17 INFORMANT Kanti Patel		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7400 IMMEDIATE CAUSE (a) <u>Chronicity</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 19 min.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 5-29, 19 82, to 5-30, 19 82, that (we) lost saw the deceased alive on 5-30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE RAYMOND J. GIBBONS					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-30-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND J. GIBBONS					22e. ADDRESS 2404 BLUERIDGE AVE WHEATON MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 3 1982				

Handwritten notes and stamps, including "Patent" and "U.S. Patent Office".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13387	
1. DECEASED NAME (TYPE OR PRINT) Kevin Rodney Paul						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 5 DAY 15 YEAR 1982		2b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH Sept. DAY 2 YEAR 1965		6. AGE (IN YEARS) LAST BIRTHDAY 16 YEARS 16 MONTHS 16 DAYS 16 HOURS 16 MIN.		7c. DATE PRONOUNCED DEAD MONTH 5 DAY 18 YEAR 1982		7d. HOUR 2:20P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Potomac Area			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South of Caderock on Potomac River			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Adelphi						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2500 Osage Street			
14. FATHER'S NAME FIRST Joseph MIDDLE Paul LAST						15. MOTHER'S MAIDEN NAME FIRST Shirley MIDDLE Furtrell LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 931 40 0148		17. INFORMANT ADDRESS Joseph Paul-Father-5203 Newton St. Bladensburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:PM P.M. 5/15 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) tried to swim river					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river found south of Caderock, Potomac Area, MontCo, MD		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Not a cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H.R. Guard				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 5/19/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Hampton Memorial Gardens		23d. LOCATION CITY OR TOWN Hampton COUNTY Virginia STATE			
24. FUNERAL DIRECTOR NAME Stewart Funeral Home				ADDRESS 4001 Benning Road, NE.		DATE MAY 21 1982		SIGNATURE			

NOTICE

2020



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1235.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 3 3 8 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JOSEPH M Pawloski		2a. DATE OF DEATH MONTH DAY YEAR 5 27 82		2b. HOUR 7 ^{PM}			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 29 33		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electronics			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12201 Hunters Lane	
14. FATHER'S NAME FIRST MIDDLE LAST John Charles Pawloski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Sobeski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 202-26-2194		17. INFORMANT ADDRESS Bjorg L. Pawloski-Same as items 13a-e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrauterine tumor 2396 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 5/20/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intrauterine tumor		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 5/18/82 to 5/27/82, that (1) (we) last saw the deceased alive on 5/27/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur Libelsky		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/28/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Libelsky		22e. ADDRESS 1119 Rockville Pike		Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		25a. RECEIVED BY REGISTRAR 1502							
1331 Rockville Pike		Rockville, Maryland							

JOSEPH M Bawloski

Male White 9 23 33

X

Silver Spring Holy Cross Hospital

MD MONTGOMERY KOSKIN X

2 30 88 118

18

15501 Hunters Lane

John James Bawloski John

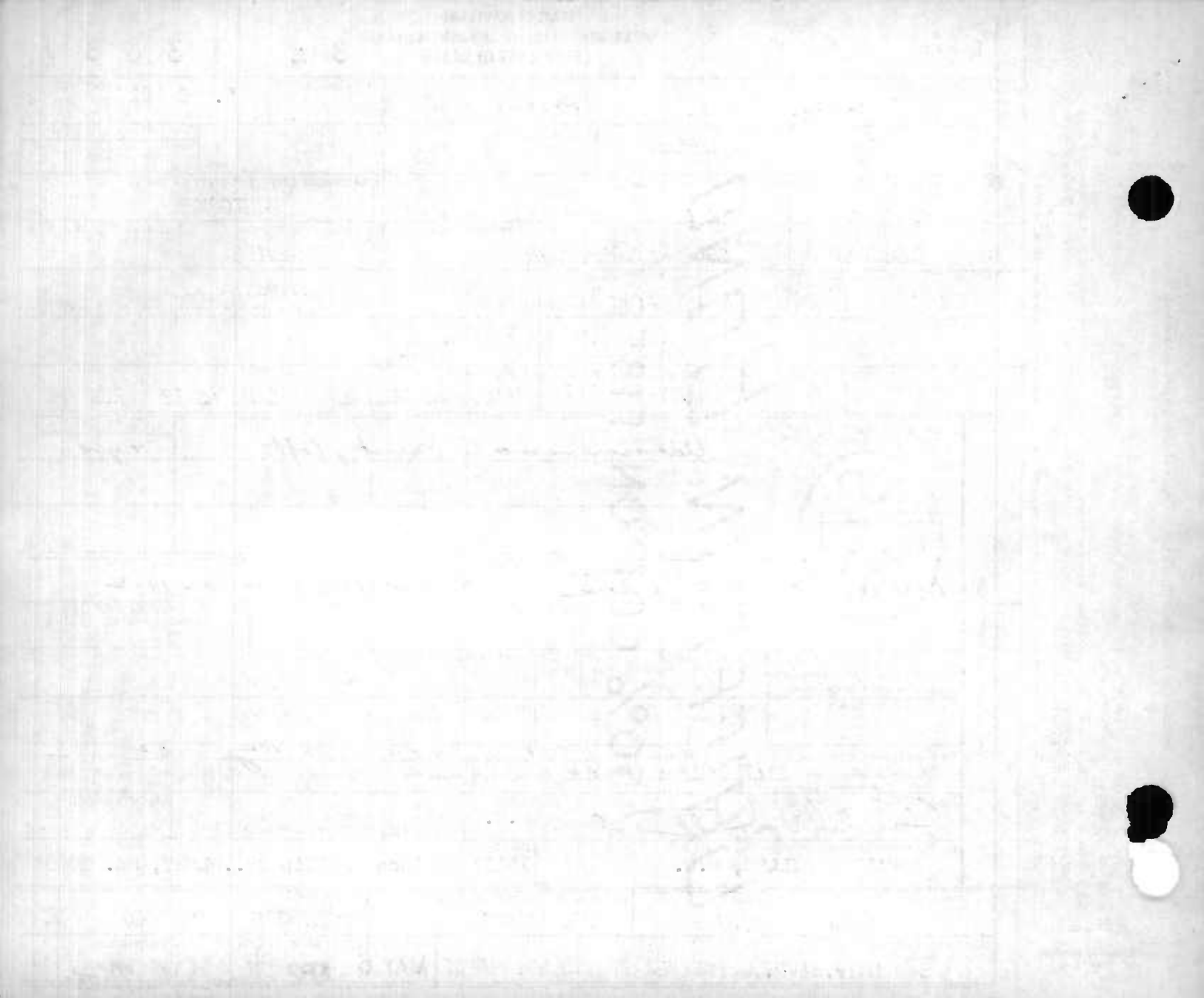
Yes 100-26-215-1 John J. Bawloski - no on 11-11-19-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 3 8 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH 5 DAY 3 YEAR 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST Gladys M. LAST Phobus				2b. HOUR 10:48 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 9 DAY 17 YEAR 20		6. AGE (IN YEARS (LAST BIRTHDAY)) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2502 RANDOLPH ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13e. STREET ADDRESS 2502 RANDOLPH ROAD 20902	
14. FATHER'S NAME FIRST CLAUDE MIDDLE LAST MARSHALL				15. MOTHER'S MAIDEN NAME FIRST GRACE MIDDLE LAST WALKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-20-6767		17. INFORMANT LLOYD A. PHEBUS		ADDRESS SAME AS 13 HUSBAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of breast, left 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastasis to brain & bone. (b) metastasizing for cancer 1962							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/6/82, 1982, to 3 May, 1982, that (I) (we) last saw the deceased alive on 15 Mar, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Donald E. Dillon				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 4, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E DILLON, M.D.				22e. ADDRESS 18111 Prince Philip Dr..OLNEY, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/6/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate must be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15.4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div> <div>1. DECEASED NAME (TYPE OR PRINT)</div> <div>2. DATE OF DEATH</div> </div>											
<div> <div>3. SEX</div> <div>4. RACE</div> <div>5. DATE OF BIRTH</div> <div>6. AGE (IN YEARS LAST BIRTHDAY)</div> </div>											
<div> <div>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>9. BALTIMORE CITY OR COUNTY OF DEATH</div> </div>											
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</div> <div>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> </div>											
<div> <div>13a. STATE</div> <div>13b. COUNTY</div> <div>13c. CITY OR TOWN</div> <div>13d. INSIDE CITY LIMITS?</div> <div>13e. STREET ADDRESS</div> </div>											
<div> <div>14. FATHER'S NAME</div> <div>15. MOTHER'S MAIDEN NAME</div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)</div> <div>16b. SOCIAL SECURITY NO.</div> <div>17. INFORMANT (SON)</div> <div>ADDRESS</div> </div>											
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>DUETO, OR AS A CONSEQUENCE OF (b)</div> <div>DUETO, OR AS A CONSEQUENCE OF (c)</div> </div>											
<div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> </div>											
<div> <div>19a. DATE OF OPERATION</div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20a. AUTOPSY?</div> <div>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</div> </div>											
<div> <div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>21b. TIME OF INJURY</div> <div>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</div> </div>											
<div> <div>21d. INJURY OCCURRED</div> <div>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</div> <div>21f. LOCATION</div> </div>											
<div> <div>22a. I certify that (I) (this hospital) attended the deceased from</div> <div>22b. DATE SIGNED</div> </div>											
<div> <div>22c. SIGNATURE</div> <div>22d. ADDRESS</div> </div>											
<div> <div>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</div> <div>23b. DATE</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>23d. LOCATION</div> </div>											
<div> <div>24. FUNERAL DIRECTOR</div> <div>25a. DATE RECEIVED BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> </div>											

TO THE
HONORABLE
MEMBERS OF THE
COMMISSIONERS OF THE
LAND OFFICE
OF THE STATE OF NEW YORK
IN SENATE
JANUARY 1880

111
1880-1881

29th MAY 1880

TO THE
HONORABLE
MEMBERS OF THE
COMMISSIONERS OF THE
LAND OFFICE
OF THE STATE OF NEW YORK
IN SENATE
JANUARY 1880

TO THE
HONORABLE
MEMBERS OF THE
COMMISSIONERS OF THE
LAND OFFICE
OF THE STATE OF NEW YORK
IN SENATE
JANUARY 1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 9 1			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Antonia nmnn Pietrantonio						May 5 1982				5:30 P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Mar 2, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2509 Hayden Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Antonio nmnn Pietrantonio						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olimpia nmnn Emanuelli							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 580-44-3410		17. INFORMANT ADDRESS Jorge Felices-Pietrantonio see 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA 1830 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from NOV 12 , 19 79 , to MAY 5 , 19 82 , that (I) lost saw the deceased alive on MAY 5 , 19 82 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.													
22b. SIGNATURE Edward G. Beeman						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 6, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Beeman, M.D.						22e. ADDRESS 8330 Cameron St. Silver Spg. Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5-6-1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo. Md.					
24. FUNERAL DIRECTOR NAME W.W. Chambers Co, 8655 Georgia Ave., Sil. Spg.						25a. DATE REC'D BY REGISTRAR MAY 10 1982		25b. PLACE OF SIGNATURE					

19 2 19

International

19 2 19

22

1

19 2 19

19 2 19

only 6,300

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

19 2 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death be certified by a physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1/81
(VRA 15, 4)

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 3 9 2
REG. NO.

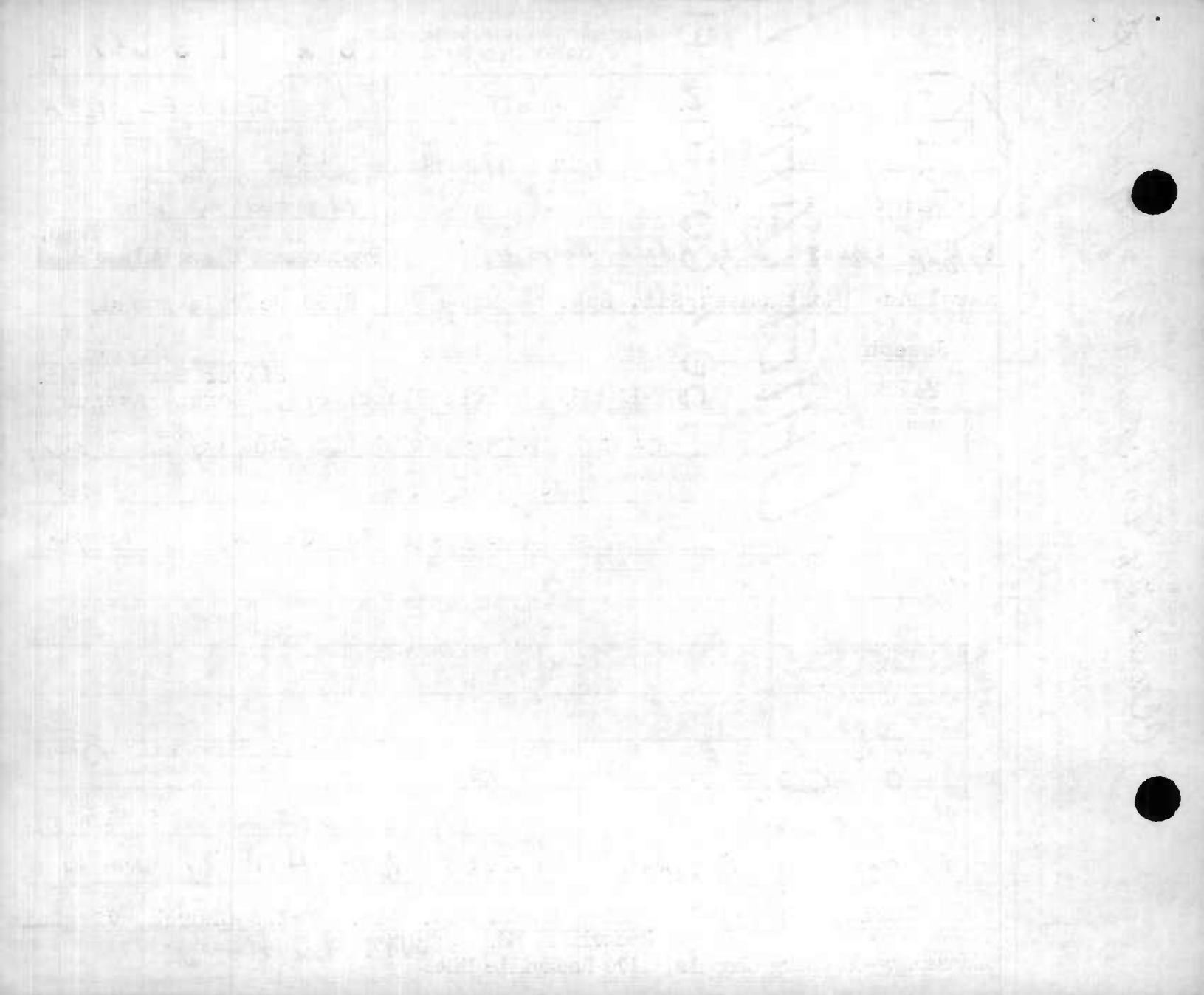
1. DECEASED NAME (TYPE OR PRINT) HENRY L. PLATT			2a. DATE OF DEATH MONTH DAY YEAR 5-29-82			2b. HOUR 12³⁰ A.M.			
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 17 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Procurement Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hosp. Walter Reed	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8750 Georgia Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Platt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Caplan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 578-12-4365		17. INFORMANT ADDRESS Silver Spring, Md. Sylvia Platt; 8750 Georgia Avenue			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke, Posterior cerebellar artery occlusion 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cv Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 5 days 10 yrs 15 yrs
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------------------------------------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from March , 19 65 , to 5-29 , 19 82 , that (1) (we) lost saw the deceased alive on 5-28 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard H. Ostron DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-29-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD H OSTRON				22e. ADDRESS 5225 Pooks Hill Rd BETH MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25. DATE REC'D. BY REGISTRAR JUN 4 1982 REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/BI
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 3 9 3			
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAYME PLITMAN						2a. DATE OF DEATH MONTH DAY YEAR May 7, 1982		2b. HOUR 8:40pm			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 15, 1899		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Wash.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6121 Montrose Road					
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Snitz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-48-1607B		17. INFORMANT ADDRESS Bethesda, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1820 DUE TO, OR AS A CONSEQUENCE OF (b) Endometrial Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 6 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the undersigned) attended the deceased from 12/15 , 19 77 , to 5/7/ , 19 82 , that (I) (we) saw the deceased alive on 5/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death .													
22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED 5-8-1982									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL, M.D.				22e. ADDRESS 6121 Montrose Road; Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-9-1982		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.							
24. FUNERAL DIRECTOR Danzansky-Goldberg Chapels 1170 Rockville Pike; Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

Item 153 6/25/82 GAB

FOR
STATE REGISTRAR

Per call from F.H. 7/9/82

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

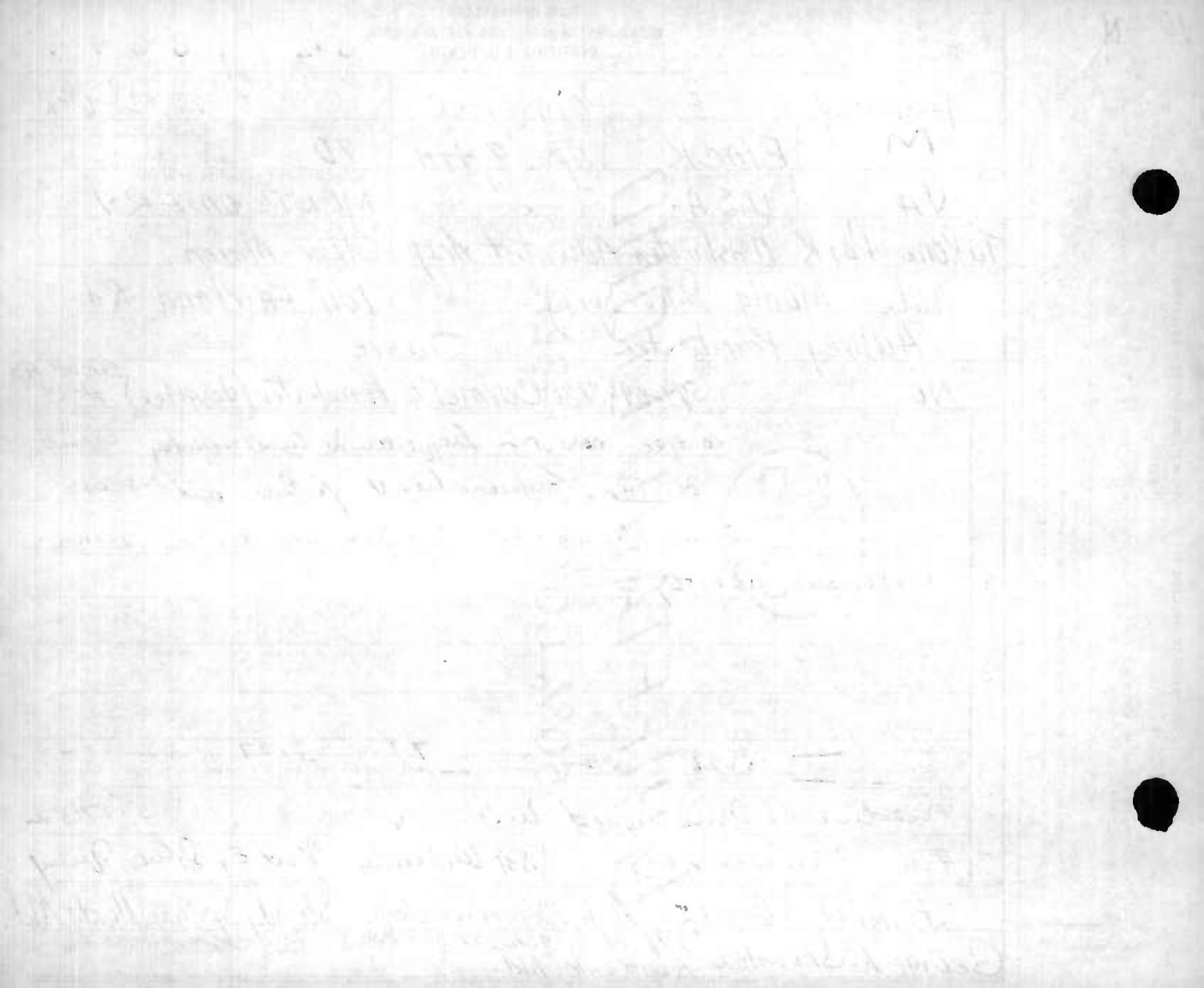
REG. NO.

8 2 1 3 3 9 4

1. DECEASED NAME (TYPE OR PRINT) Aubrey E. Poindexter			2a. DATE OF DEATH MONTH DAY YEAR 5 27 82			2b. HOUR 6:12 A.M.			
3. SEX M		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Apr. 8, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stone Mason		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montg		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1011 Fairland Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Aubrey Poindexter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dusie Hill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OF UNKNOWN)		16b. SOCIAL SECURITY NO. 579-09-3830		17. INFORMANT ADDRESS Carmelita Poindexter (daughter) #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cadence arrest - hypertensive cardiovascular 4029 DUE TO, OR AS A CONSEQUENCE OF (b) chronic heart failure and years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF chronic obstructive pulmonary disease, years.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): respiratory distress					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 79 , to 5-27-82 , that (I) (we) lost saw the deceased alive on 5-26-82 , 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Medicus W. Muenkel MD				22c. DATE SIGNED 5-27-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.W. BRENNWALD				22e. ADDRESS 831 University Blvd E, Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montg Md.		24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden 246 N. Wash. St. Rockville, Md.			
25a. DATE AND BY REGISTRAR (TYPE OR PRINT)					

BP



08:00 02:00

02:00 04:00

04:00 06:00

06:00 08:00

08:00 10:00

10:00 12:00

12:00 02:00

02:00 04:00

04:00 06:00

06:00 08:00

08:00 10:00

10:00 12:00

12:00 02:00

02:00 04:00

04:00 06:00

06:00 08:00

08:00 10:00

10:00 12:00

12:00 02:00

02:00 04:00

04:00 06:00

06:00 08:00

08:00 10:00

10:00 12:00

12:00 02:00

02:00 04:00

04:00 06:00

06:00 08:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly filled out, this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 2 1 3 3 9 6 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie M. Poole		2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982		2b. HOUR 1:55 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1893		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 88 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Cen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charwoman		12b. KIND OF BUSINESS OR INDUSTRY Bur. Engraving			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 504 Rittenhouse St., N. W.	
14. FATHER'S NAME FIRST MIDDLE LAST Pierce Davenport		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Anderson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 579-03-2227		17. INFORMANT ADDRESS 504 Rittenhouse St NW Lula M. Lewis-Daughter-Washington, D. C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK 10 YRS 10 YRS								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 72 to 59 82, that (I) (we) last saw the deceased alive on 4-17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Erwin Ardam		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/9/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERWIN ARDAM		22e. ADDRESS 5454 WILSON ST AVE CLARKSBURG							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-13-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR NAME T.C. Binkney		ADDRESS 524-8th St. N.E.		25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE James J. Hester			

MAILED

6103 902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 (1989) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8213397 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN NMI POSTAL					2a. DATE OF DEATH MONTH DAY YEAR 5 7-82					2b. HOUR 6:18 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1900		6. AGE (IN YEARS) (LAST BIRTHDAY) 82		7. UNDER 1 YEAR MONTHS DAYS YRS.		7. UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer (Ret)			12b. KIND OF BUSINESS OR INDUSTRY Food				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2311 Peggy Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Postal					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda (UNK) ✓								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 577-48-1568			17. INFORMANT ADDRESS IDA POSTAL; 2311 Peggy Lane; Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 LEFT LOWER LOBE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN ORG. ANISMS DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a 2. 9. DIFFUSE EXUDATIVE BRONCHITIS; HYPER-OSMOLAR DIABETIC COMA													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/2/82 to 4/7/82, that (I) (we) last saw the deceased alive on 4/7/82, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.													
22b. SIGNATURE A. W. ...			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/7/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL					22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD.								
23a. BURIAL, CREMATION, REMOVAL (SEE IF Y)			23b. DATE May 9, 1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GDN.: FALLS CHURCH, FAIRFAX, VA.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR MAY 11 1982			25b. REGISTRAR'S SIGNATURE [Signature]					

1 3 2 2 1



1950

Left Coast Local Chapter
1950

DEFINITIVE EXHIBITIVE PRESENTING

1951 85 1951 85
1951 85 1951 85
1951 85 1951 85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 3 9 8

1. DECEASED NAME (TYPE OR PRINT) Charles Percy Powell			2a. DATE OF DEATH MONTH DAY YEAR 5-13-82		2b. HOUR 4:48 P.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 7, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp - 1500 Fort St. Road		12a. USUAL OCCUPATION Superintendent of Manuscripts of Congress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Day Powell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Linville			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-44-9930		17. INFORMANT ADDRESS Mrs. Marie W. Powell, Wife, Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Corrupt Heart Failure 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Cornary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 15 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal Failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 82 to 5/13 , 19 82 , that (I) (we) last saw the deceased alive on 5/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R. Cioffi		DEGREE MD		22c. DATE SIGNED 5/15/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Cioffi		22e. ADDRESS 10620 BG Ave S.S. Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Winston-Salem, North Carolina		24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				
25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan				

BP

1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 3 9 9											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M			
Charles		L.		Pressley				5 26 82		3:30AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
male		white		3 28 1916		66							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
South Carolina		USA				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery Gen. Hospital				retired U.S.		Government					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Wheaton		YES		12709 Gould Road					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Charles C. Pressley		Annie Bowie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
yes		WW II		238-07-9693		Doris Pressley same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>RENAL FAILURE</u> (c) <u>CORONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>G.I. BLEEDING - PARALYTIC ILEUS - CONGESTIVE FAILURE</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>82</u> , to <u>MAY-25</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-25-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>R. Q. Mathew, MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5-26-82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
RAFAEL A. MATHEUS		13018 GEORGIA AVE., WHEATON, MD 20906											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		5/28/82		Parklawn Memorial Park		Rockville, Maryland							
24. FUNERAL DIRECTOR NAME				24b. ADDRESS				25. DAY RECEIVED BY REGISTRAR				26. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc.				1331 Rockville Pike Rockville, Maryland				MAY 28 1982				<u>James J. Nathan</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 1/81
(VRA 15, 4)

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		6 2 1 3 4 0 0	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		REG. NO.	
Joshua N. Prout		5/12/82		6:15pm	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		Negro		March 19 1900	
6. AGE (IN YEARS LAST BIRTHDAY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
62				Prince George	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Takoma Park		Washington Adventist Hospital		Cook	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince Geo.		Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
John L. Prout		Susie Morsell		no	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Complications of the liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Subdural Hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Contance Daughton		11215 Oak Leaf Drive			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27/82</u> to <u>5/12/82</u> , that (I) (we) lost saw the deceased alive on <u>5/12/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 5/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
ABRAHAM DABELA		4404 Queensbury Rd Riverdale MD		MAY 18 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 15-82		Harmony Memorial PARK	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. CITY OR TOWN	
Johnson & Jenkins 716 Kennedy St. NW.		MAY 18 1982		Prince Geo. MD	



main

negro

March 17 1900

SS

Myland

WMA

Prince George

Leone Park

Washington and vicinity

Book

colored

also Geo. Henry Smith

1115 and 1117

John

i.

from

social

possibly

no

1900-1901

Washington and vicinity

[Faint handwritten notes and scribbles in the center of the page.]



main

May 12-00

Myland, Prince George

also Geo. Henry Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jed NMN Prunier			2a. DATE OF DEATH MONTH DAY YEAR 5 10 82			2b. HOUR 9:00 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 10 20		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR IF UNDER 24 HRS. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Fuel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Montgomery CITY OR TOWN Silver Spring		13b. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 11607 Dewey Road					
14. FATHER'S NAME FIRST MIDDLE LAST Jed Louis Prunier				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cara Jamison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II 577-24-3978		17. INFORMANT Rockville, Md. 20853 Roger L. Prunier 13534 Vandalia Dr.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CARDIORESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **TUBERCULOSIS + PSEUDOMONAS SEPSIS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

RESPIRATORY INSUFFICIENCY

19a. DATE OF OPERATION 4/16/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY INSUFFICIENCY SECONDARY TO BROMOPNEUMONICAL FISTULA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/2 , 19 82 , to 5/10 , 19 82 , that (I) (we) last saw the deceased alive on 5/10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kathleen F. Cheyney		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHLEEN F. CHEYNEY MD		22e. ADDRESS 18111 PRINCE PHILIP DR., OLNEY, MD 20832					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR MAY 13 1982		25. REGISTRAR'S SIGNATURE Kathleen F. Cheyney	
NAME 1331 Rockville Pike Rockville, Md. 20852				ADDRESS			

2000

• • •

reiner

2001. 10. 1. 10. 1. 10. 1.

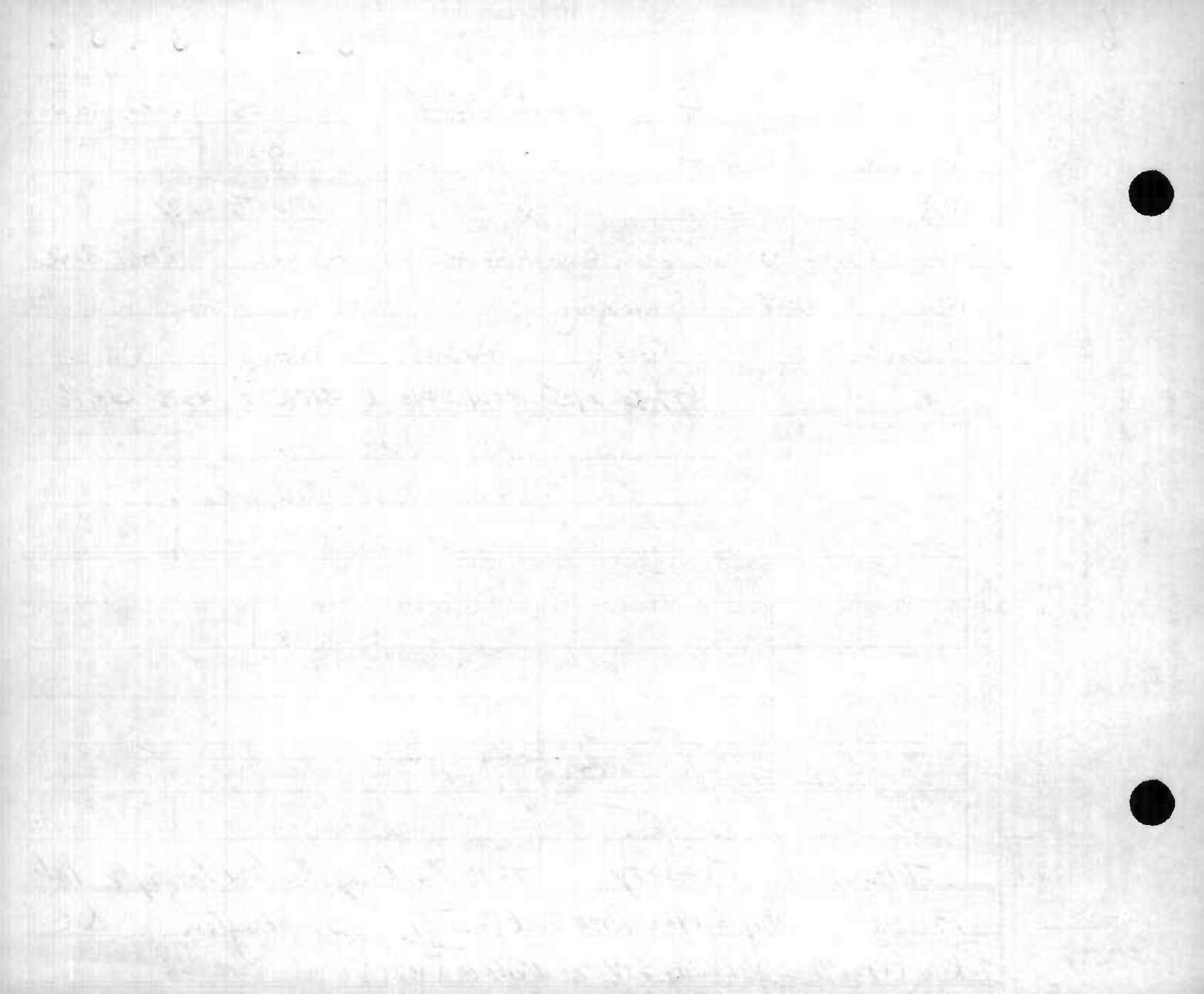
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 0 2					
1. DECEASED NAME (TYPE OR PRINT) Thelma G. Pumphrey										2a. DATE OF DEATH MONTH 5 DAY 12 YEAR 82				2b. HOUR 12:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY RIGGS BANK							
13a. STATE MD				13b. COUNTY MONT		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8114 New Hampshire Ave #23					
14. FATHER'S NAME FIRST Charles MIDDLE LAST Grey				15. MOTHER'S MAIDEN NAME FIRST Hester MIDDLE Mary LAST Cage											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-34-2905		17. INFORMANT ADDRESS MARY SANE L. BARRETT, 4205 54th Pl.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis general CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8 May 1982 to 12 May 1982 , that (I) was last saw the deceased alive on 12 May 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, in (we) (did) (did not) view the body after death.															
22b. SIGNATURE Thomas P. Fogarty				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12 May 82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Fogarty				22e. ADDRESS 7676 New Hampshire Ave Langley Pk. Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC							
24. FUNERAL DIRECTOR NAME Takoma Funeral Home				ADDRESS 2500 Carroll St		25. DATE REC'D. BY REGISTRAR MAY 14 1982		25. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

Item #5 5/20/82 rc

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8213403

1. DECEASED NAME (TYPE OR PRINT) John FAY Putnam			2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982		2b. HOUR 4:45 AM
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR May 5 1924	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MILWAUKEE, WISC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1905 Hopfield Rd, Sil Spg, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDUCATOR		12b. KIND OF BUSINESS OR INDUSTRY Dept of Education
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md			13c. COUNTY Montgomery	13d. CITY OR TOWN Silver Spring	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John FAY Putnam			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Agnes Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 397-18-8415	17. INFORMANT Address Carolyn S. Putnam Wife 1905 Hopfield Rd, Sil Spg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 1420 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA of PAROTID GLAND (Left)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 1981 to May 9, 1982, that (I) (we) last saw the deceased alive on May 6, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Carol Jean Smith, M.D.		DEGREE		22c. DATE SIGNED 9 May 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL JEAN SMITH, MD		22e. ADDRESS 15612 Good Hope Rd, Silver Spg, Md, 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/82	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville, Mont Md.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H.Ave.S.S.Md.			25a. DATE REC'D. BY REGISTRAR May 13 1982		
			25b. REGISTRAR'S SIGNATURE		

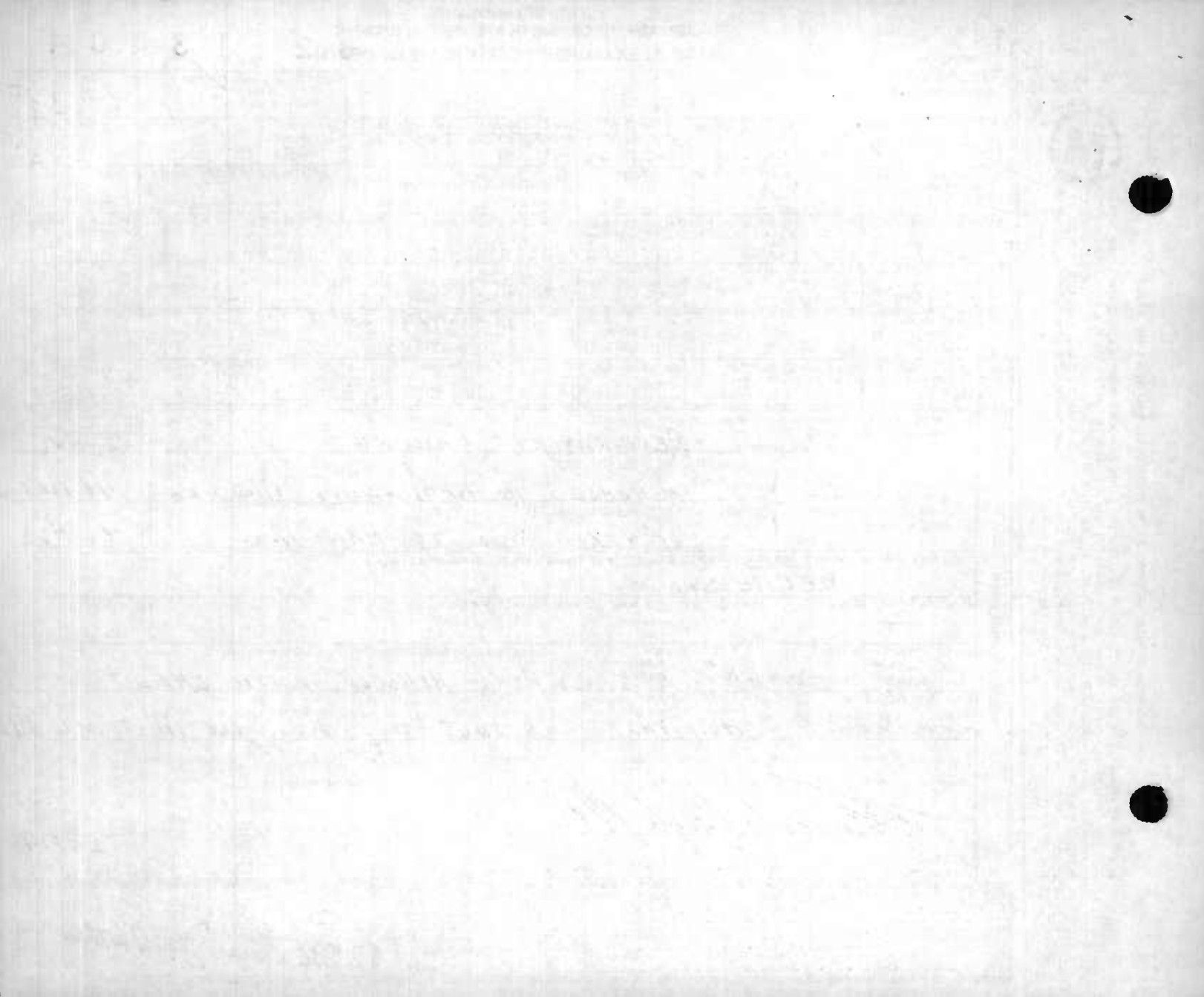
601281

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 4 0 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Mary Patricia Rankin								May 8, 1982								3:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Cauca.	Mar. 14, 1948		34 YRS.						May 8, 1982						3:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Indiana		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County, MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Rockville		Shady Grove Adventist Hosp.		Homemaker		Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Virginia		Henrico		Richmond		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		214 Banbury Road									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
John Cogan				Patricia Figge													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
No				288 46 0432				Husband				214 Banbury Road Thomas T. Rankin Richmond, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u>INCREASED INTRACRANIAL PRESSURE</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u>ANOXIA DUE TO HANGING</u>																	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
2 HRS																	
48 HRS																	
48 HRS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
<u>DEPRESSION</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				6:10 P.M. 5 5 1982				HUNG HERSELF WITH SHEET									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				HOSPITAL				CHESTNUT LODGE ROCKVILLE MONTGOMERY MD									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
TITLE (SPECIFY) Deputy MEDICAL EXAMINER																	
DATE SIGNED May 8, 1982																	
ACTUAL SIGNATURE Francis C. Mayle, M.D.																	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D. 8200 Wisconsin Avenue Bethesda, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				May 10, 1982				Lake View Cemetery				Cleveland Ohio					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND																	
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 12 1982 James J. Nathan																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Louise Raven			20. DATE OF DEATH MONTH DAY YEAR 5/21/82		2b. HOUR 3³⁵ pm
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 10 85		6. AGE (IN YEARS LAST BIRTHDAY) 97	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Pr Geo	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LUCIEN Pelletier		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NORA McCormick		13e. STREET ADDRESS 205 Lakeside Drive #102	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 323 40 6583		17. INFORMANT ADDRESS George W. Raven Sameas #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 82 , to 5/21 , 19 82 , that (I) (we) last saw the deceased alive on 5/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA MD		22e. ADDRESS 4404 Queensbury Rd Riverdale MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25 May 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, MD	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, PG Md		23e. DATE OF BURIAL, CREMATION, REMOVAL JUN 2 1982			
24. FUNERAL DIRECTOR NAME ADDRESS Robert E. Wilhelm Funeral Home Suitland, MD					

1948-1949



MINISTRY OF
DEFENSE
OFFICE OF THE
SECRETARY
GENERAL
WASHINGTON, D.C.



MINISTRY OF
DEFENSE
OFFICE OF THE
SECRETARY
GENERAL
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 0 6	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
		Hattie M. Ratliff				May 14 1982		7:20 A.M.			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Nov. 11 1900		81 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg		Wilson Health Care Center		Housewife		-					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS					
Md.		Montgomery Gaithersburg				15821 Quince Orchard Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Andrew Jackson Mobley		Harriett A. Selby									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS							
No		-		212-74-9467		Doris Chamberlain		1694 Grandview Rd., Pasadena, Md. 21122			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) HEALING LEFT FRACTURED FEMUR. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days, years.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HEALING LEFT FRACTURED FEMUR.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from Sept 19 50, to 14 May 19 82, that (I) saw the deceased alive on May 9 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
John Fawcett, M.D.						5/14/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5/17/82		Forest Oak Cemetery		Gaithersburg Montg. Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Gartner Sandison F. H.		316 E. Diamond Ave. Gaithersburg, Md. 20877		MAY 18 1982							

BP



Nov. 11 1920

Washington

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



5/11/21

[illegible]

[illegible]

[illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Amanda F. Redmiles			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1982			2b. HOUR 6:50pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Howard 13c. CITY OR TOWN Lisbon			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 16370 Old Frederick Road			
14. FATHER'S NAME FIRST David MIDDLE Foster LAST			15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE Kibler LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 12 4358A		17. INFORMANT ADDRESS David Redmiles same as above				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) ARDS severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 82 , to 5/16 19 82 , that (I) (we) lost saw the deceased obv , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. L. [Signature]			22e. ADDRESS 18111 Pr Philip Dr Olney Md 2082						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home,			ADDRESS Laurel, Md			25a. DATE REC'D. BY REGISTRAR MAY 26 1982			
						25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

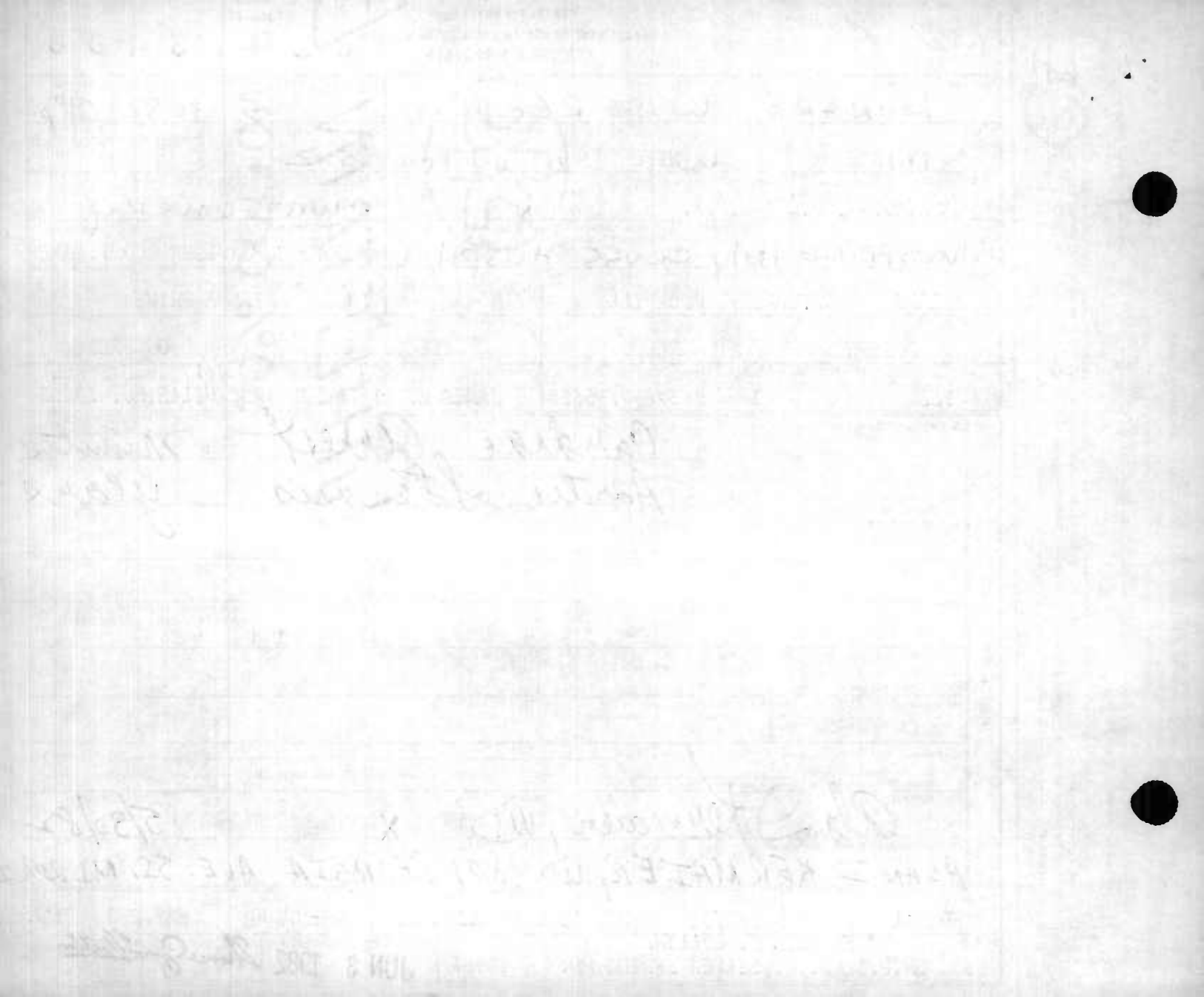
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 4 0 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LEONARD W AYNE Reed				2a. DATE OF DEATH MONTH DAY YEAR 5 30 82			
3. SEX MALE				2b. HOUR 6¹⁰ PM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 04 00		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVERSPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ROUTE SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY CONT. BAKERY	
13a. STATE MARYLAND				13b. STREET ADDRESS 13600 MARIANNA DRIVE			
13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH REED				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZZIE GODFREY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 1 578-07-5623		17. INFORMANT SON ADDRESS 4417 IVES STREET			
				JAMES R. LITTLETON ROCKVILLE, MD. 20853			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteric Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) 4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.							
22b. SIGNATURE Alan I. Kermatier, MD				DEGREE MD		22c. DATE SIGNED 5/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD				22e. ADDRESS 9801 GEORGIA AVE. SS. MD 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/2/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JUN 3 1982			
NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE Francis J. Collins			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 0 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margret L Reel		2a. DATE OF DEATH MONTH DAY YEAR 5/26/82		2b. HOUR 11:50 PM	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR June 27 1907	
6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS 74		IF UNDER 24 HRS. HOURS MIN. 11:50 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STATE Maryland	
13b. COUNTY Montg		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 17801 October CT		14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN FRANK THOMAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ERMA UNK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS R.W. DEBNAM see 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE Open Fungus on Cerebrum Right Base DUE TO, OR AS A CONSEQUENCE OF (b) 1749 DUE TO, OR AS A CONSEQUENCE OF (c) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)					
19a. DATE OF OPERATION 1749		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1749		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M. 19 82	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, BARN, ETC.) 16 May 82	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 26 May 82		21g. CERTIFY THAT (I) (this hospital) attended the deceased from saw the deceased alive on 26 May 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		21h. SIGNATURE Merton L White M.D.	
21i. PHYSICIAN'S NAME (TYPE OR PRINT) Merton L WHITE M.D.		21j. ADDRESS 9911 Georgia Ave Silver Spring Md 20902		21k. DATE SIGNED 27 May 82	
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		22b. DATE 5-28-1982		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo., Md.		22e. DATE REC'D. BY REGISTRAR 1 1982		22f. REGISTRAR'S SIGNATURE 1 1982	
23. FUNERAL DIRECTOR NAME ADDRESS W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg,					

MEDICAL CERTIFICATION

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

1111 1111 1111 1111 1111 1111 1111 1111 1111 1111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		Elsie I. Reigel.				8 2 1 3 4 1 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Elsie		MIDDLE I		LAST REIGEL.		2a. DATE OF DEATH MONTH DAY YEAR 5-8-82	
3. SEX Female.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7b. HOUR 7:20 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lykens, Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> , DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.			
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital. House Wife.							
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland.		13b. COUNTY Montg.		13c. CITY OR TOWN Takoma Park.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8606 Garland Ave. Tak. Pk.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Bowman.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida, Unknown.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 195-07-7606		17. INFORMANT Lemoyne, Pa. A. Musselman Funeral Home.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 4299 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEVERE ORGANIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) the hospital attended the deceased from FEB 19 82 to MAY 8 19 82 , that (I) found lost saw the deceased alive on 7 MAY 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did did not view the body after death.									
22b. SIGNATURE <i>Marcell C. Quinnam Jr</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL Burial.		23b. DATE May 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Enola Cemetery.		23d. LOCATION CITY OR TOWN COUNTY STATE Enola, Pa.			
24. FUNERAL DIRECTOR <i>Marcell C. Quinnam Jr</i>				25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE <i>Marcell C. Quinnam Jr</i>			

Dr. Quinnam contacted Dr. Wheeler Corona 5/9/82

• 55113

42

• **מחשבות**

• 2 •

Henry Howard.

sbI

• *continued*

• 29 •

192-07-7600 A. Wangelman, Bureau of Census, Wash., D.C.

• 64

• *Journal of the American Medical Association*

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary W. Reilly		2a. DATE OF DEATH MONTH DAY YEAR May 18, 1982		2b. HOUR 11:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1909	
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 72 MONTHS 0 DAYS		8. IF UNDER 24 HRS. HOURS MIN. 0 HOURS 0 MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? USA		9c. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18901 Cloverhill Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY own home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 18901 Cloverhill Lane,		14. FATHER'S NAME FIRST MIDDLE LAST John Gilmore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Holmes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213 40 8710		17. INFORMANT Same as above ADDRESS Francis J. Reilly (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 7070 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Senility					
19a. DATE OF OPERATION June 14, 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Senility		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19		22a. I certify that (I) (this hospital) attended the deceased from June 14, 1982 to May 18, 1982 , that (I) (we) last saw the deceased alive on May 14, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.		22b. SIGNATURE Mehdi Farzin MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 5-18-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mehdi Farzin, MD		22e. ADDRESS Suite M-16 6201 Greenbelt Rd., College Pk., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi 11800 N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR MAY 20 1982	
25b. REGISTRAR'S SIGNATURE Thomas J. Reilly					

BP_____

DHMH-16 25M
(VRA 15, 4) 1/79

402

gey

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 1 2

REG. NO.

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MICHIKO (NMN) REMINGTON

2a. DATE OF DEATH MONTH DAY YEAR
MAY 31, 1982

2b. HOUR
7:40pm

3. SEX
Female

4. RACE
Other

5. DATE OF BIRTH MONTH DAY YEAR
January 21, 1930

6. AGE (IN YEARS LAST BIRTHDAY) YRS.
52

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
JAPAN

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD.

10. CITY OR TOWN OF DEATH
Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, NIH, Bethesda, Md

12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Ret. P. Geo. Co. Housing Agency

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE
Maryland

13b. COUNTY
P. Geo.

13c. CITY OR TOWN
Bowie

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS
12108 Tulip Grove Drive

14. FATHER'S NAME FIRST MIDDLE LAST
Unk.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unk.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
218-52-8241

17. INFORMANT ADDRESS
Kenneth G. Remington, husband, same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiorespiratory Arrest**
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes
1719
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF **Hemangiopericytoma**
9 years
(c) DUE TO, OR AS A CONSEQUENCE OF **Hypoglycemia**
4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ☒ (this hospital) attended the deceased from **May 10**, 19**82**, to **May 31**, 19**82**, that ☒ (we) last saw the deceased alive on **May 31**, 19**82**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (not) view the body after death.

22b. SIGNATURE
Ronald G. Steis

DEGREE
M.D.

22c. DATE SIGNED
6/1/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ronald G. Steis

22e. ADDRESS
**National Institutes of Health
Clinical Center, Bethesda, Md 20205**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
6-4-82

23c. NAME OF CEMETERY OR CREMATORY
Md. Vet. Cemetery

23d. LOCATION CITY OR TOWN COUNTY
Cheltenham Pr. Geo. Md.

24. FUNERAL DIRECTOR NAME
Beall Funeral Home

24b. ADDRESS
16,000 Annapolis Rd. Bowie, Md.

25a. DATE REC'D. BY REGISTRAR
JUN 7 1982

25b. REGISTRAR'S SIGNATURE
[Signature]

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 1 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		5		3 8 2 5 18 PM	
Ernest L Rexrode											
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.	
male		white		MONTH DAY YEAR		78		YRS.			
10. CITY OR TOWN OF DEATH		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
VA.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		CONSTRUCTION		CONSTRUCTION					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		P.G. CO.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5902 31st Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
PERRY - REXRODE		LESSIE - REID									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		NONE		191-03-5051		DOLA F. REXRODE (WIFE) SAME AS #13.					
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2030		Septicemia				Myeloma		2 wks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								1 yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (1) this hospital attended the deceased from 5/3/82 to 5/3/82, that (2) (we) lost saw the deceased alive on 5/3/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) see the body after death.											
22b. SIGNATURE		DEGREE		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
Myron L. Lenkin						MYRON L. LENKIN		2309 Shorefield Rd Wheaton Md		5/3/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		MAY 6, 1982		CLOVER HILL CEM.		DAYTON, VIRGINIA					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
CHAMBERS FUNERAL HOME		MAY 10 1982		RIVERDALE, MD.							

1211

23822

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR											
REG. NO. 8 2 1 3 4 1 4											
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR A M		
Lloyd Michael Rhea						May 25, 1982			7:10 A M		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		08/08/1957		24 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		USA				Montgomery MD					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			U.S. Navy (Ret)			U.S. Govt		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET ADDRESS		
Texas Tarrant			Fort Worth			YES			2872 Centre Court		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Daniel W. Rhea			Betty A. Stamper								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
Yes			unk			242-92-5875 Mrs. Betty A. Rhea, mother, same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Sepsis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
2001 DUE TO, OR AS A CONSEQUENCE OF (b) Probable Candidal Esophagitis										3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoblastic Lymphoma/Leukemia										2½ years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cachexia											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 March 19 82 to 25 May 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 May 19 82, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above.											
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS								
JOHN HORNEFF			The Clinical Center, National Institutes of Health, Bethesda, Md 20205								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE		
Cremation			5-26-1982			Cedar Hill Crematory Suitland, Prince Geo, Md					
24 FUNERAL DIRECTOR NAME			ADDRESS			25a EXAMINED BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
W.W. Chambers Funeral Home			Silver Sprg, Md.			MAY 28 1982			Francis J. Nathan		

1 3 1 1 1

121

May 22, 1963

John

101

22

1963

101

101

1963

101

101

1963

The United States

101

1963

1963

101

1963

101

101

1963

101

101

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 1 5			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Franklin Richard							2a. DATE OF DEATH MONTH DAY YEAR May 23, 1982			2b. HOUR 7:00 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 19, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 34		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Food Industry					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Tennessee							13b. CITY OR TOWN Dyersburg		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Route 3 38024		
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Richard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane nmnn Cook									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1967-1970		17. INFORMANT Mrs. Jane Richard, Mother, same as patient							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2002 DUE TO, OR AS A CONSEQUENCE OF (b) Malignant lymphoma - probably Burkitt's DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1982, to May 23, 1982, that (we) (we) last saw the deceased alive on May 23, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.													
22b. SIGNATURE James W. Hathorn						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/23/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Hathorn						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-27-1982		23c. NAME OF CEMETERY OR CREMATORY Dyer County Men Gard Dyersburg, Dyer, Tennessee		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg.						25a. DATE REC'D. BY REGISTRAR MAY 28 1982		25b. REGISTRAR'S SIGNATURE James W. Hathorn					

STANDARD

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50



11/10/50

11/10/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 1 6
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVELYN			2a. DATE OF DEATH MONTH 5 DAY 17 YEAR 82			2b. HOUR 8 1/2 AM					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 5 DAY 2 YEAR 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD		
10. CITY OR TOWN OF DEATH Washington			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY DC 13c. CITY OR TOWN Washington						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS #12 1745 Montana Avenue, N.E.		
14. FATHER'S NAME FIRST Moses MIDDLE Willis LAST Virginia						15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Nelson LAST Nelson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 255 18 4789			17. INFORMANT Terry Rogers-son-			ADDRESS D.C. 2129 3rd Street, N.E.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 5		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 16 1982 to May 17 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Salvador E. Perez		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALTAZAR E. PEREZ, M.D.		22e. ADDRESS 10620 Georgia Ave Silver Spring, Md - 20902					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 22 1982		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Park-Landover, Maryland	
24. FUNERAL DIRECTOR NAME John T. Stewart III				25a. DATE REC'D. BY REGISTRAR MAY 24 1982			
25b. REGISTRAR'S SIGNATURE Stewart Funeral Home-4001 Benning Rd. N.E.							

0101 20

23 08 1943

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3417			
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET J ROSE						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5/23 1982		2b. HOUR 9:53					
3. SEX female		4. RACE cauc		5. DATE OF BIRTH MONTH DAY YEAR 3-15-44		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/23/1982		2d. HOUR 9:53	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary				12b. KIND OF BUSINESS OR INDUSTRY I.A.M.A.W.	
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 15524 Peach Orchard Rd, 20904			
14. FATHER'S NAME FIRST MIDDLE LAST John J. Mahaney						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jane Behrend							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-42-2644		17. INFORMANT LARRY D. ROSE HUSBAND				ADDRESS 15524 Peach Orchard SS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 9520 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Carbon Monoxide</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>													
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5:23 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Sitting in car with engine running in garage</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Peach Orchard Rd. Silver Sp. Mont. Md.</u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John S. Rogers</u>						TITLE (SPECIFY) M.D. <u>Dep.</u> MEDICAL EXAMINER				DATE SIGNED <u>May 23 1982</u>			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.						ADDRESS 1919 Seminary Road Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>					
ADDRESS 500 University Boulevard, W Silver Spring, Md.													

VI. 6

THE UNIVERSITY OF CHICAGO
LIBRARY



LIBRARY
THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

LIBRARY
THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

LIBRARY
THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13418	
1. DECEASED NAME (TYPE OR PRINT) Patrick A. Ross							2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-29-82		2b. HOUR 8:34		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3-17-14	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 68	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 29 1982		2d. HOUR 8:34			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Tk. Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse man			12b. KIND OF BUSINESS Jacobus Transfer Co.			
13a. STATE MD				13b. CITY OR TOWN Prine Georges Beltsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 11439 Cherry Hill Rd			
14. FATHER'S NAME FIRST MIDDLE LAST John Ross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridgett McHugh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 11 203-01-3995		17. INFORMANT ADDRESS Minnie L. Ross-wife- (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. D.M.				MEDICAL EXAMINER				DATE SIGNED May 29 1982	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1919 Seminary Rd., S.S. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-1982		23c. NAME OF CEMETERY OR CREMATORY George Washington				23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. Georges Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home-Sil. Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan					

BP

10-10-1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		8 2 1 3 4 1 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) WILLIS J. ROYER					2a. DATE OF DEATH MONTH DAY YEAR 5/05/82			2b. HOUR 1:25am M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 23 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9 Wolf Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel B. Royer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Z. Zug							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II		16b. SOCIAL SECURITY NO. 197-10-5487		17. INFORMANT ADDRESS Ruth M. Royer same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia + Lung hemorrhage 2051 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC MYELOGENOUS LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 6 YRS.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from out 10 19 76 , to 5 May 19 82 that (I) (we) lost saw the deceased alive on 5 May 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene P. Libre		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5 May 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE M.D.		22e. ADDRESS 10400 CONNECTICUT AVE KENSINGTON, MD. 20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Norbeck Mont. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Lyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25. DATE REC'D. BY REGISTRAR MAY 10 1982					

1:25pm

PROCES

197-10-2487

197-10-2487

197-10-2487

Montgomery

USA

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

197-10-2487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

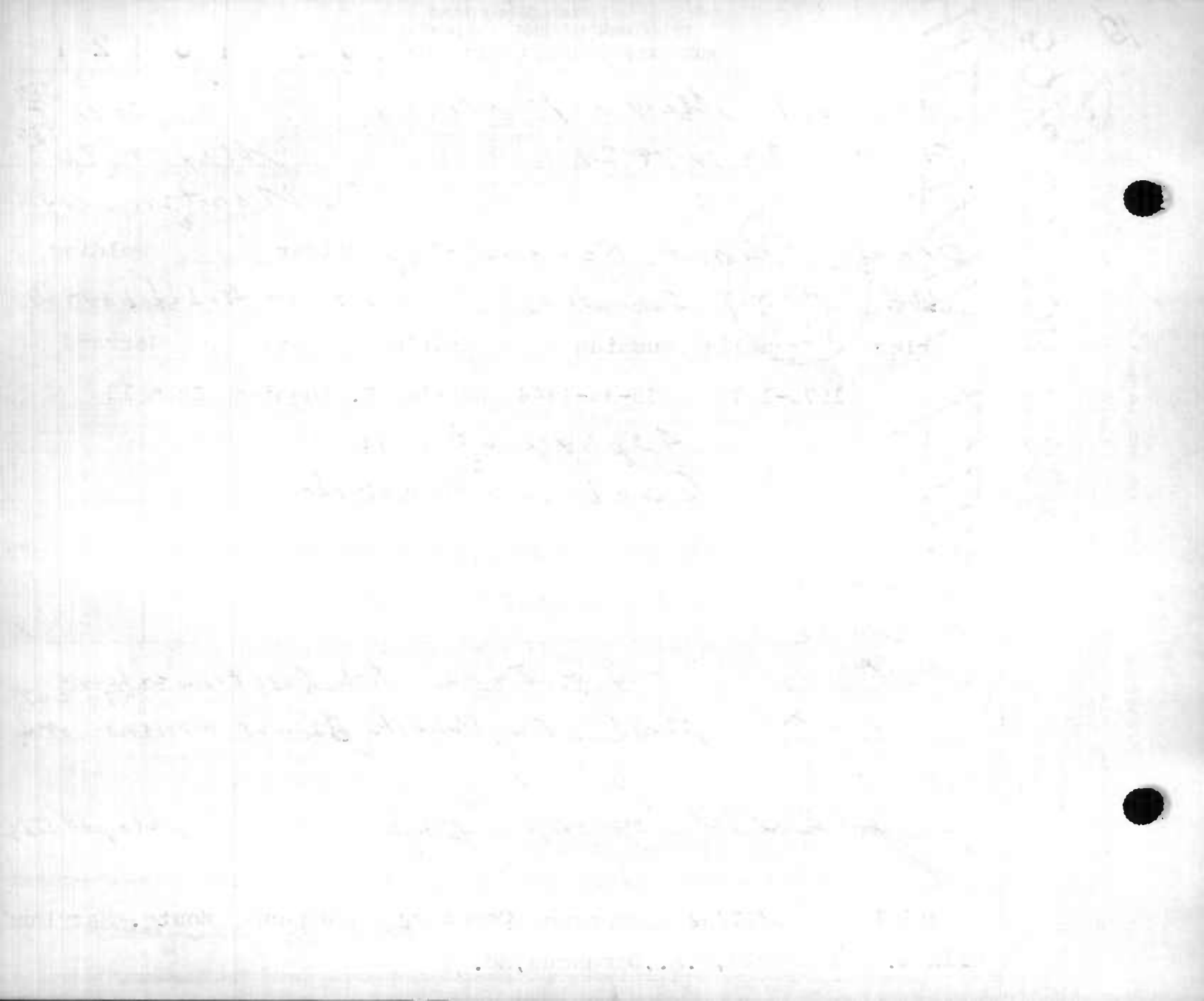
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 4 2 0							
1. DECEASED NAME (TYPE OR PRINT) Nicholas J. Ruitenber					2a. DATE OF DEATH MONTH May DAY 10 YEAR 1982			2b. HOUR 8:16 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH Feb. DAY 25 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 128 New Mark Esplanade		
14. FATHER'S NAME FIRST Nicholas MIDDLE J. LAST Ruitenber					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Finn LAST Finn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea		17. INFORMANT wife ADDRESS Erna A. Ruitenber Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) acute cerebral vascular accident (c) severe coronary artery disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/2 , 19 82 , to 5/9 , 19 82 , that (I) (we) lost saw the deceased alive on 5/9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph M. Solinas M.D.						DEGREE MD		22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Solinas, M.D.						22e. ADDRESS 9801 Georgia Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE 		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Marie Jean Nathan	

BP

BP_____

DHMH - 17
(VR A15 ME (3))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3421			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR			
Michael		Melvin		Rushing				May 24 1982		5:55 PM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
M	W	Oct 24 54		27 YRS.						May 24 1982			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Hawaii		USA				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Mont. General Hosp				Welder		Welding					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
MD		Monte		Damascus				10224 Mid Lebanon Dr.					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charles Franklin Rushing				Shirlee Mae Garrard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Yes		1975-1978		035-38-4944		Charles F. Rushing Item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 9520 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Carbon Monoxide (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
None													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 524 PM		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) In car with loose trim exhaust into car									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Field		21f. LOCATION STREET CITY OR TOWN COUNTY STATE King Valley Rd. Damascus Mont. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER				DATE SIGNED May 24 1982							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5/27/82		Damascus Cemetery				Damascus Montgomery Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE OF DEATH BY REGISTERAR										25b. REGISTERAR'S SIGNATURE	
Olin L. Molesworth, P.A.,		Damascus, Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 4 2 2							
1. DECEASED NAME (TYPE OR PRINT) John Thomas Ryan					2a. DATE OF DEATH MONTH DAY YEAR May 6, 1982			2b. HOUR 3:40 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/02/1949		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY N.U.S. Trg.Ctr.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9120 Bramble Bush Court	
14. FATHER'S NAME FIRST MIDDLE LAST John Ryan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa McCarthy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 059-42-8520		17. INFORMANT ADDRESS Linda P. Ryan (wife) same			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4241 Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) End Stage Cardiac Disease DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Stenosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION May 6, 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Aortic Stenosis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 May 1982, to 6 May 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 6 May 1982, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Robert Applebaum M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT APPLEBAUM M.D.			22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-11-1982		23c. NAME OF CEMETERY OR CREMATORY Vestal Hills Memo.Park		23d. LOCATION CITY OR TOWN COUNTY STATE Vestal New York Broome Cty.		
24. FUNERAL DIRECTOR NAME Gartner-Sandison Funeral Home ADDRESS 316 E. Diamond Ave. Gaithersburg, Maryland									
25. DATE REC'D. BY REGISTRAR MAY 11 1982									



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 2 3

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH S. SAGONA, SR.		2a. DATE OF DEATH MONTH DAY YEAR 5/13/1982		2b. HOUR 8:00 AM	
3 SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCT 2, 1917		6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREIGN SERVICE OFFICER		12b. KIND OF BUSINESS OR INDUSTRY GOVT. U.S.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12606 EASTBOURNE DRIVE 20904	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL SAGONA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA SEDITA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 134-05-8178		17. INFORMANT ADDRESS FRANCES T. SAGONA SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute carcinoma of lung</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/82</u> to <u>5/12/82</u> , that (I) (we) lost saw the deceased alive on <u>5/12/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>E. J. Levin MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE H. LEVIN		22e. ADDRESS 8430 FETTER ST			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAY 17 1982 <u>Francis J. Collins</u>			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

Handwritten notes and diagrams on lined paper, including a large circular diagram on the right side and various scribbles and markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 8 2 1 3 4 2 4							
I. DECEASED NAME (TYPE OR PRINT) Claudia L. M. B. Schatz				2c. DATE OF DEATH MONTH DAY YEAR 5/29/82		2b. HOUR 12 56 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 7, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY H.E. W.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Guy McGrone				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Burnes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-60-0691		17. INFORMANT ADDRESS Dorothy Proctor 5911 - 15th Ave. Hyatts.Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 5860 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart disease failure DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/21 , 19 82 , to 5/29 , 19 82 , that (I) (we) lost saw the deceased alive on 5/29 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. H. E. Smith				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. E. Smith				22e. ADDRESS 8323 Haddon DR TAKOMA PK					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash. D.C. 20016				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

MEDICAL CERTIFICATION

4-12-74

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

41. [Illegible]

42. [Illegible]

43. [Illegible]

44. [Illegible]

45. [Illegible]

46. [Illegible]

47. [Illegible]

48. [Illegible]

49. [Illegible]

50. [Illegible]

51. [Illegible]

52. [Illegible]

53. [Illegible]

54. [Illegible]

55. [Illegible]

56. [Illegible]

57. [Illegible]

58. [Illegible]

59. [Illegible]

60. [Illegible]

61. [Illegible]

62. [Illegible]

63. [Illegible]

64. [Illegible]

65. [Illegible]

66. [Illegible]

67. [Illegible]

68. [Illegible]

69. [Illegible]

70. [Illegible]

71. [Illegible]

72. [Illegible]

73. [Illegible]

74. [Illegible]

75. [Illegible]

76. [Illegible]

77. [Illegible]

78. [Illegible]

79. [Illegible]

80. [Illegible]

81. [Illegible]

82. [Illegible]

83. [Illegible]

84. [Illegible]

85. [Illegible]

86. [Illegible]

87. [Illegible]

88. [Illegible]

89. [Illegible]

90. [Illegible]

91. [Illegible]

92. [Illegible]

93. [Illegible]

94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

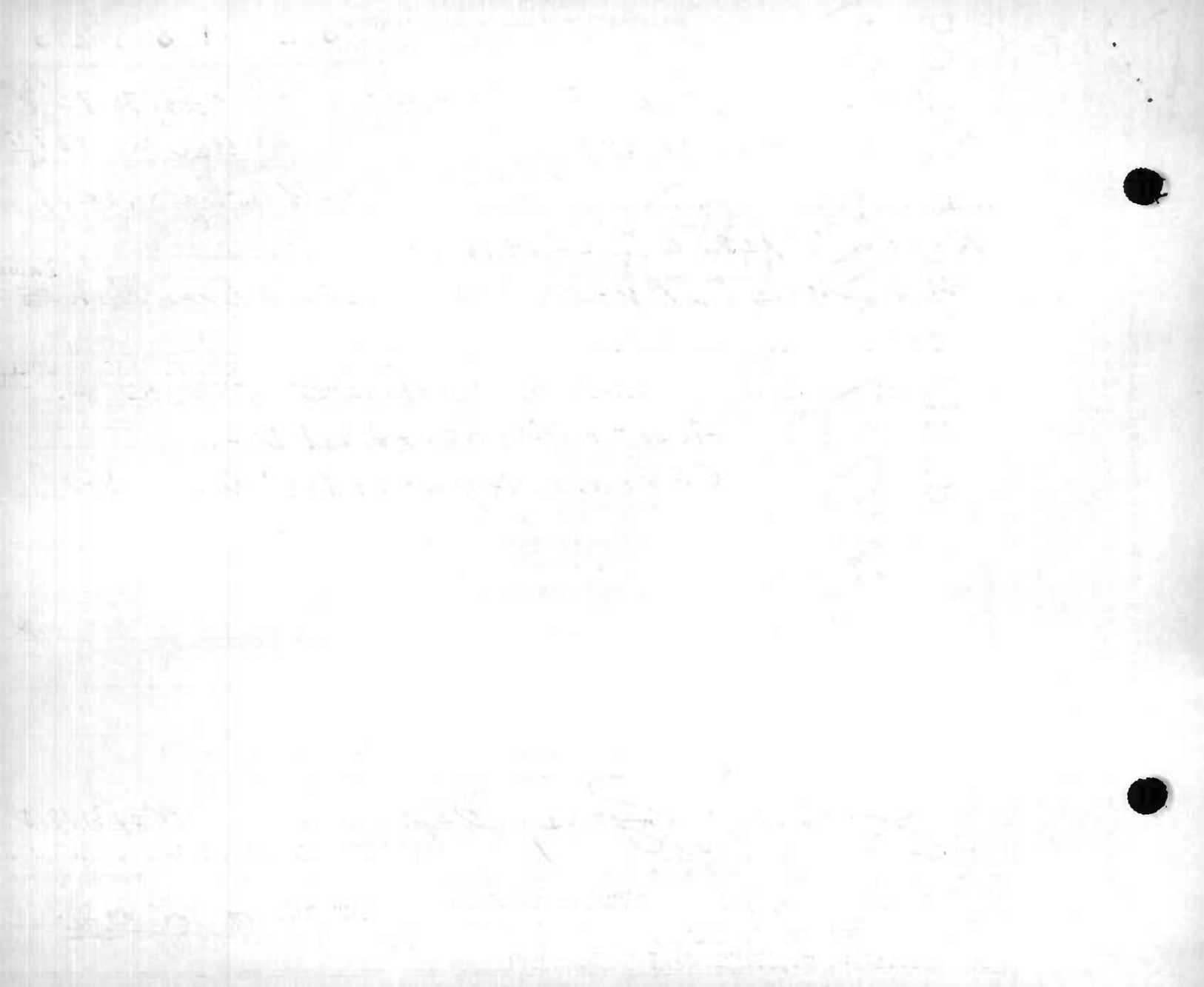
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		9 2 1 3 4 2 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Robert Schmidt</i>		20. DATE KNOWN OF DEATH MONTH DAY YEAR <i>May 30 19 82</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>April 24 23 52</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>29</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12820 Evenston St</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>	
13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>12820 Evenston St</i>		13f. STREET ADDRESS <i>DRIVE</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES C. SCHMIDT</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LYDA MAE GUNN</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>577-26-3927</i>	
17. INFORMANT <i>MOTHER</i>		ADDRESS <i>3589 S. LEISURE WORLD BLVD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Chronic Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yrs</i>		4291	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a: <i>None</i>			
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>		ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6/2/82</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROCKVILLE MONT MD.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		25. DATE FILED BY REGISTRAR <i>JUN 3 1982</i>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR				8 2 1 3 4 2 6					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
MAX MAX SCHOR				5-13-82				1:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. YRS.	
MALE		WHITE		2 06 09		73			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross				RECEPTOR		RADIO	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Montgomery		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8301 16th St. #104	
14. FATHER'S NAME (TYPE OR PRINT)				15. MOTHER'S MAIDEN NAME					
LEWIS				SCHÖRR				JENNIE TEITELBAUM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO				067-01-7590		840 EAST 18th STREET MOLLIE GREENMAN, BROOKLYN, NEW YORK			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1519 IMMEDIATE CAUSE (a) Cardiac arrest								minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) Massive myocardial infarction - Minutes									
(c) Status post gastrectomy								8 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
5-5-82				Carcinoma Stomach				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				P.M. 19				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-29 1982 to 5-13 1982, that (I) (we) lost the deceased alive on 5-13 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Leonard L. Deit				MD				5-14-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
LEONARD L. DEIT				1980 FOREST GLEN RD SILVER SPRING, MD 20910					
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL				5/16/1982		WELLWOOD CEMETERY		PINELAWN, LONG ISLAND, NEW YORK	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						MAY 18 1982			

Items #10a-22a Film G569 7/12/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 4 2 7

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
HERTA S. SCHULACHER SCHULER						5-26-82													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		2c. DATE PRONOUNCED		2d. HOUR					
FEMALE		WHITE		APRIL 10, 1917		65 YRS.		MONTHS DAYS		HOURS MIN.		5-26-82		12:00 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
WISCONSIN				U.S.A.								Montgomery County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Springs				210 Northmoor Drive				TYPIST											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MARYLAND				MONTGOMERY				SILVER SPRING				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				210 NORTHMOOR DRIVE			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST								FIRST MIDDLE LAST											
PAUL SCHUMACHER								UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO								394-10-3011				DAUGHTER				MARYLAND			
												DIANE MULLENS 118 LEXINGTON DR, SILVER SP							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Drowning complicating drug overdose</u>																			
9505 { DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR				self/ingested											
				P.M. 5/27/82															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				bathtub				210 Schuler Northmoor Dr. Silver Spring Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED							
Margarita A. Koroll				M.D. Assistant MEDICAL EXAMINER								5-27-82							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Margarita A. Koroll, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				5/29/82				ST. PAUL'S CEMETERY				COPPERSBURG LEHIGH PA							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
FRANCIS J. COLLINS				JUN 1 1982				Francis J. Collins											
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



LETTER 4
DOWD

NOV 20 1900

TO THE
HONORABLE
SIR
THE
ATTORNEY GENERAL
WASHINGTON
D.C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry that I cannot give you a more definite answer at this time, but the matter is being considered by the proper authorities.

I am, Sir, very respectfully,
Yours,
J. H. DOWD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the appropriate death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8 2 1 3 4 2 8			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) ELSIE E. SCHWEGMANN				2a. DATE OF DEATH MONTH 5 DAY 22 YEAR 82 2b. HOUR 8 15 ^P _M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 20 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE --- COUNTY ---		13b. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3534 Porter Street, N.W.	
14. FATHER'S NAME FIRST Joseph MIDDLE --- LAST Elchinger				15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE --- LAST Fourneret			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --- 578-62-9500		17. INFORMANT ADDRESS 7507 Salem Road Falls Church, Va.		17. INFORMANT George C. Schwegmann	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION				ONE DAY			
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ORGANIC BRAIN SYNDROME				YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c) ---							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE INANITION, SEVERE ANEMIA, DYSKINESIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 13, 1979 to May 22, 1982 , that (I) (we) last saw the deceased alive on 5/12/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Martin C. Shagel DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHAGEL				22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON MD 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/26/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE	
24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc.				25. AUTHORIZED BY (TYPE OR PRINT) MAY 26 1982 Charles J. Nathan			
5130 Wisconsin Avenue, N.W.-Washington, D.C.							

BP _____

0 2 1 2 3 4

RECEIVED

DATE

NAME

ADDRESS

POSTOFFICE

LOCATION

DATE

NAME

LOCATION

POSTOFFICE

LOCATION

POSTOFFICE

POSTOFFICE

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

NAME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ANN					2a. DATE OF DEATH MONTH DAY YEAR 5 2 1982				
3. SEX Female					2b. HOUR 7⁰⁰ AM				
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 10 1910			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. New York City		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Fla.		13b. COUNTY Lauderhill		13c. CITY OR TOWN Lauderhill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4040 E.N.W. 19th Street	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Moskowitz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Forman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 052-18-5518		17. INFORMANT David Siegel Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitotic Carcinoma lungs 1718 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Rhabdomyosarcoma Right leg (c) 4 months PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months				
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/37 5/2 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8218 Wisc. Ave., Bethesda, Md.					
22a. I certify that (I) (this hospital) attended the deceased from 4/24 1982 to 5/2 1982 , that (I) (we) lost above, (I) (we) did not view the body after death.									
22b. SIGNATURE J. Blaine Fitzgerald					22c. DATE SIGNED 5/2/82			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M. D.					23b. ADDRESS 8218 Wisc. Ave., Bethesda, Md.				
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 5/5/82		23e. NAME OF CEMETERY OR CREMATORY New Montefiore Cemetery Farmingdale, N.Y.			23f. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., Sil. Spr., Md.					25a. DATE REC'D. BY REGISTRAR MAY 6 1982				
25b. REGISTRAR'S SIGNATURE Frances Van Nuthan									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 3 0					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John A. Selby										MAY 19 1982				11:00 PM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-12-1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN					
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		8b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.									
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE - 13b. COUNTY - 13c. CITY OR TOWN Wash., D.C.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5615 - 1st Street, N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST John E. Selby					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Clifford										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1913-1921		17. INFORMANT John M. Selby (Brother)		6729 Chillum Mnr. Rd. Hy., Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Metastatic adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 5/19/82 to 5/20/82, that I (we) last saw the deceased alive on 5/20/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.															
22b. SIGNATURE Barry N. Rosenbaum, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/20/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM				22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20F95											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-82		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Pr. Geo. Md.									
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE Anne G...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GAMINI TILAK SEMASINGHE					2a. DATE OF DEATH MONTH DAY YEAR May 15, 1982		2b. HOUR 7:45 p.m.		
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1936		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sri Lanka		7b. CITIZEN OF WHAT COUNTRY? Sri Lanka		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Staff Member		12b. KIND OF BUSINESS OR INDUSTRY Sri Lanka Embassy	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4905 Battery Lane, #102 20814	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Semasinghe					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malini Wijetunge				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-58-7267		17. INFORMANT ADDRESS Joan L. Semasinghe, Wife, Same as item #13					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1560 IMMEDIATE CAUSE (a) involving liver with hepatomegaly and pleura surfaces, bilateral DUE TO, OR AS A CONSEQUENCE OF (b) History of adenocarcinoma in gallbladder DUE TO, OR AS A CONSEQUENCE OF (c) Probable metastatic cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 13, 1982 , to May 15, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 15, 1982 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE John J. O'Shea MD					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-16-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. O'SHEA MD					22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory, Alexandria, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR MAY 24 1982				
					25b. REGISTRAR'S SIGNATURE Frances Santhorn				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE IN ITEM 18, "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

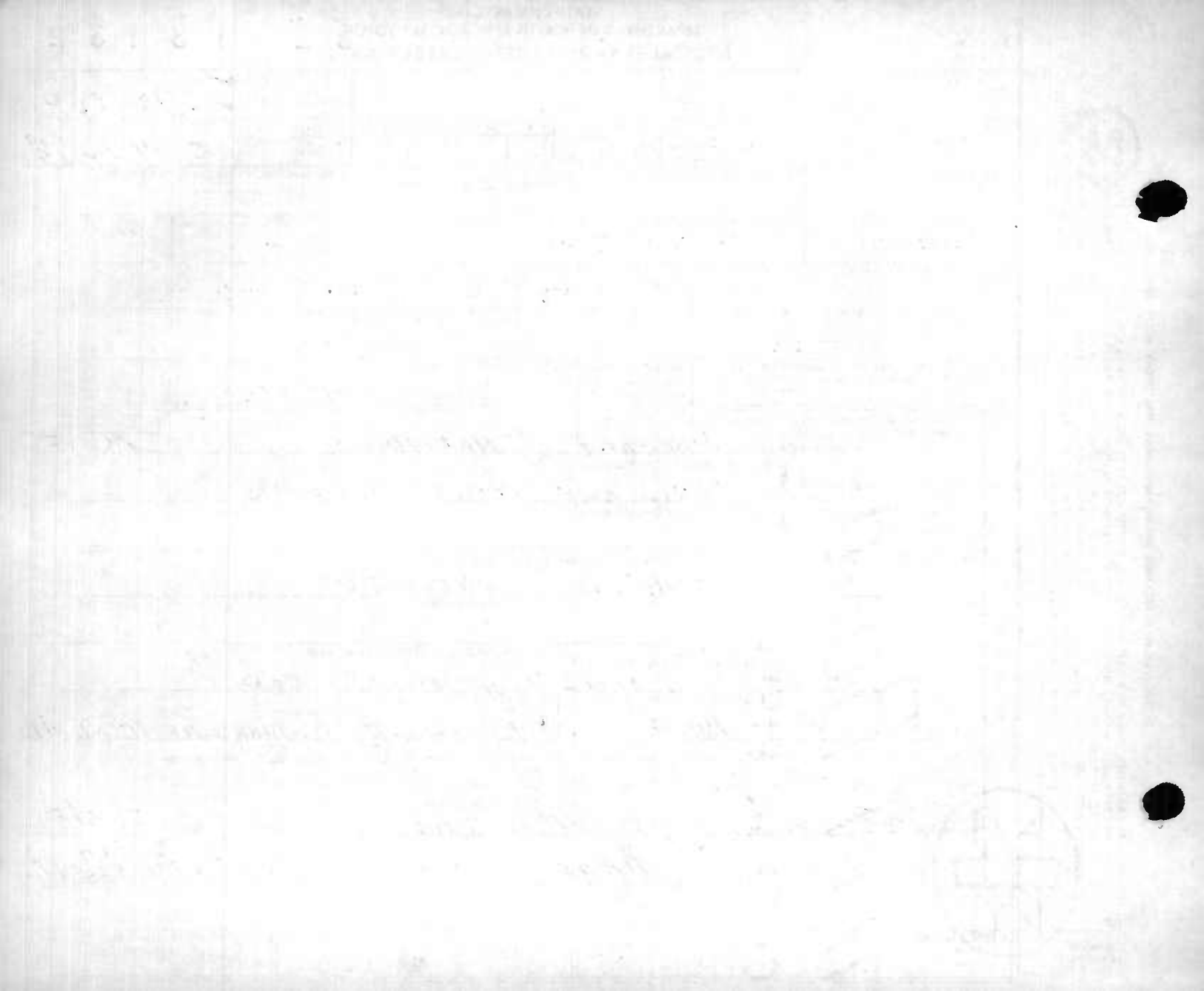
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Donald		Lee		Sewell				5		12		19		82		P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	Feb. 15, 1922		60		YRS.				5		14		19		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.										MONTGOMERY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Gaithersburg		374 N. Summit Avenue		Landscaper													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Montg.		Gaithersburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		374 N. Summit Avenue									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Richard Sewell						Bessie Dimes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WW II		214-16-7853		Mildred R. Sewell (wife) same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CEREBRAL THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ACUTE							
4100		DUE TO, OR AS A CONSEQUENCE OF		(b)		CORONARY ARTERIOSCLEROSIS											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		DIABETES MELLITUS															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		HOUR A.M.		MONTH		DAY		YEAR					
		P.M.		5 12 1982		COLLAPSED AT BED											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE					
		HOME		374 N. Summit		Gaithersburg		MONT.		MD.							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		5/15/82											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		M.D.		MEDICAL EXAMINER											
FRANCIS C. MAYHE		8200 WILSON AVE		BETHESDA MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		5-18-82		Lincoln Park Cemetery		Rockville, Montg.		Md.									
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
NAME		24b. ADDRESS		MAY 19 1982													
George R. Snowden		246 N. Washington Street		Rockville, Md. 20850													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 2 1 3 4 3 3	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna M. Shank					2a. DATE OF DEATH MONTH DAY YEAR May 25, 1982				2b. HOUR P M 2:40 P		
2. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 9, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2215 Cedar Lane Carriage Hill-Bethesda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7013 Exfair Road			
14. FATHER'S NAME FIRST MIDDLE LAST William Heffner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Worthmiller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-54-0676		17. INFORMANT ADDRESS Anita B. Flack, Niece, 4429 P St., NW, Washington, D.C. 20007							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) generalized convulsions (c) puerperal										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 20 yrs 24 hr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/11 , 19 81 , to 5/25 , 19 82 , that (I) (we) last saw the deceased alive on 5/13/82 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN [Signature]				DEGREE [Signature]				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wynn					22e. ADDRESS 7801 Norfolk Ave Bethesda, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 1 1982						
					25b. REGISTRAR'S SIGNATURE [Signature]						

BP



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "to the" and "the" are visible.

Handwritten text at the bottom of the page, including what appears to be a date "21-12-54" and other illegible notes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 7 2 1 3 4 3 4									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUBOV B Shatinsky						2a. DATE OF DEATH MONTH DAY YEAR 5-13-82		2b. HOUR 530 AM	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-5-1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTISOMERY MD.			
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CIRCLEMANOR NURSING CARE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEC'T		12b. KIND OF BUSINESS OR INDUSTRY BANK	
13a. STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN CHEVYCHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4911 FALSTONE AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE SHATKELBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PANNA BAUMGARTEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 043 28 3078		17. INFORMANT (DAUGHTER) EUGENIA TEODOLI - SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Moments years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hemorrhage into left internal capsule (CVA), old									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/1/82 to Present date that (I) (we) lost 0 view the deceased alive on 5/18/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE George C. Buchanan M.D.						DEGREE M.D.		22c. DATE SIGNED 5/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE C. BUCHANAN, M.D.				22e. ADDRESS 3301 New Mexico Ave, N.W. Washington D.C. 20006					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 15 '82		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL DIRECTOR JENSON		25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR SIGNATURE [Signature]					

MEDICAL CERTIFICATION



George Thacker
Mansfield Mont. Quaker
Kensington Circle/Mansfield Sec't. Bank
White 8-18-88
Lupin B. 2-1-88

Handwritten notes and signatures in the middle section, including a circular stamp.

Wm. 12, 82 Book (Cession)
Del. P. 12, 82 Book (Cession)
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
REG. NO. 8 2 1 3 4 3 5									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET P. SHAW						2a. DATE OF DEATH MONTH DAY YEAR 5 27 82			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 24, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7b. HOUR 3:00 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5500 FRIENDSHIP BOULEVARD 20851	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN D. PARKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 578-64-0588		17. INFORMANT ADDRESS J. ROBERT SHAW SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> 2028 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant Lymphoma</u> (c) <u>3 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> , 19 <u>82</u> , to <u>May 27 1982</u> , that (I) (we) lost <u>above</u> <u>May 27 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <u>Charles P. Mullaney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Martin</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

Released By Dr. Mayle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 3 6

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET E SHORT			2a. DATE OF DEATH MONTH DAY YEAR May 8 82		2b. HOUR 528 a m
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1891	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas --- Moffitt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose --- Noone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b. SOCIAL SECURITY NO. 218-54-8788		17. INFORMANT ADDRESS Gerald K. Cassidy, Same address as # 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Asphyxiation & Garage Loading DUE TO, OR AS A CONSEQUENCE OF (c) Monitors Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9110					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Echymosis Fracture HP					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 1 , 19 82 , to May 8 , 19 82 , that the (we) last saw the deceased alive on May 1 , 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, that (we) did (did not) view the body after death.					
22b. SIGNATURE W. Blaine Fitzgerald		DEGREE M.D.		22c. DATE SIGNED 5-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald		22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/10/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016			
25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE Charles J. Santhron			

BP

—

5230

257

1000 1000 1000

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 2 1 3 4 3 7			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					TERESA V SHUGRUE					5-17-82		8:59 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		CAUCASIAN		NOV 24, 1907		74 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MASSACHUSETTS		U.S.A.				Montgomery city MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		SALESPERSON									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			20853			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES XX NO <input type="checkbox"/>		13810 LOREE LANE						
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
HERBERT SCHINZEL					TERESA SHEA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO					039-20-7128		ROBERT H. HANSON SAME AS 13 SON-IN-LAW						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4960 Respiratory failure										3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive pulmonary disease										2+ years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/8, 19 80, to 5/17, 19 82, that (we) last saw the deceased alive on 5/17, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
SOEL A. PRISKIN, MD								5/17/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
SOEL A. PRISKIN, MD				809 VILERS MILL RD ROCKVILLE, Md. 20851									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL			5/19/82		GATE OF HEAVEN			SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						MAY 19 1982		Francis J. Collins					

BP

13.11.11

10

11

12

13

14

15

16

17

18

19

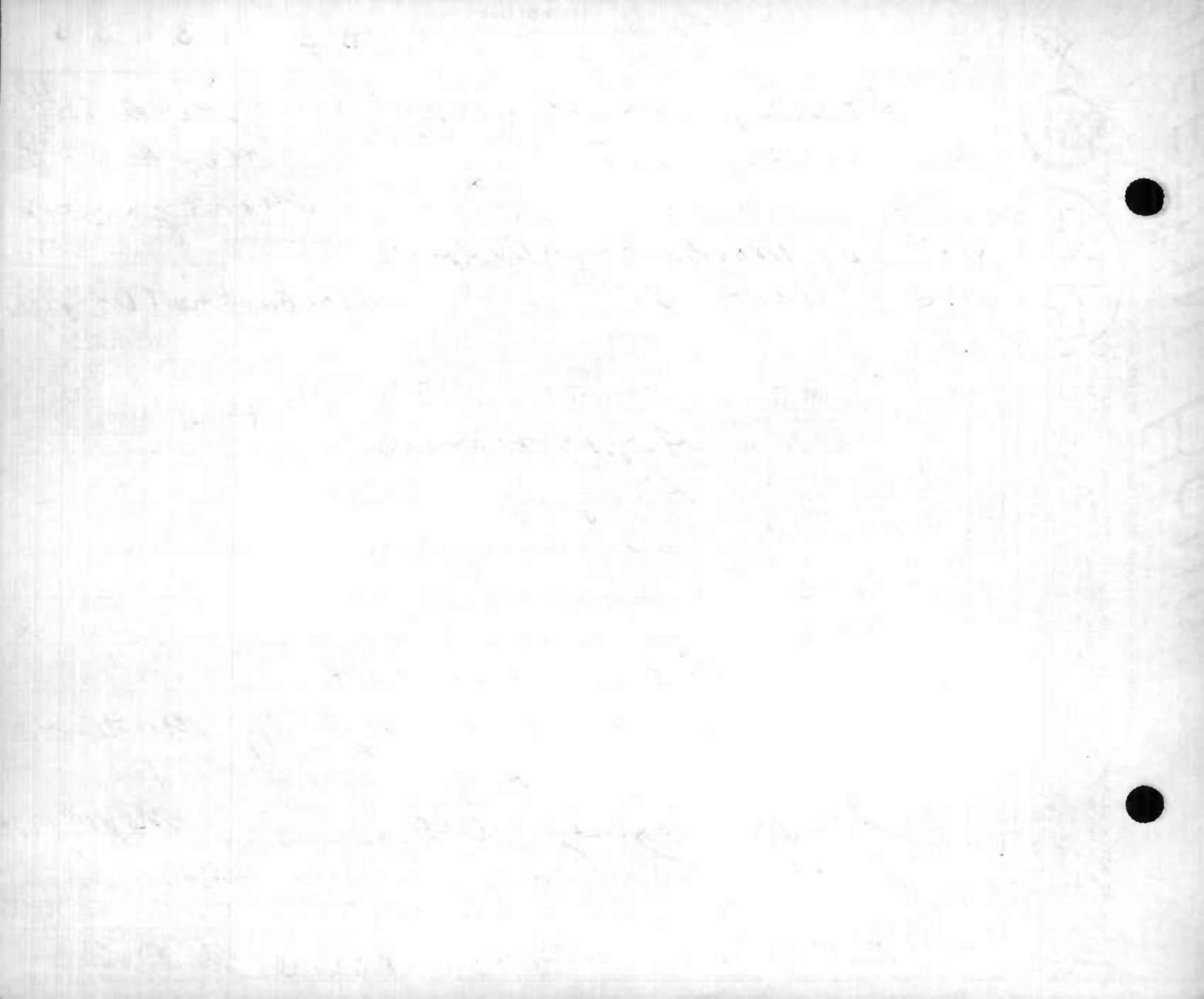
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A13 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13438			
1. FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) STANLEY ERNEST SIEGEL												2a. DATE KNOWN OF DEATH MAY 12 1982			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 13 1957		6. AGE (IN YEARS) 25		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MAY 12 1982					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH WHEATON				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11708 Bucknell Dr. Apt 101				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STATISTICIAN				12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.			
13a. STATE MD				13b. CITY OR TOWN WHEATON				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET ADDRESS 11708 Bucknell Dr. Apt 101			
14. FATHER'S NAME ALBERT						15. MOTHER'S MAIDEN NAME JEAN SCHOLNICK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 132-16-7679		17. INFORMANT ELIOT J. SIEGEL,				304 J NORTH CHAPELGATE LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Hanging DUE TO, OR AS A CONSEQUENCE OF (c)												BALTIMORE, MARYLAND			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
None															
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 10:30 P.M. 5/12/82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hung self							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION Bucknell Dr. B.L. Vpp CITY OR TOWN Wheaton COUNTY Montgomery STATE MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER 1919 SEMINARY ROAD				DATE SIGNED MAY 12 1982			
EXAMINER'S NAME (TYPE OR PRINT) DR. JOHN S. ROGERS, M. D.				ADDRESS SILVER SPRING, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 5/14/1982		23c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEMETERY				23d. LOCATION STATEN ISLAND, NEW JERSEY					
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D.C.												25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 4 3 9
CERTIFICATE OF DEATH

FOR
1- STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SYLVIA Sirkis			2a. DATE OF DEATH MONTH DAY YEAR 5 19 82		2b. HOUR 5:45 A.M.				
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 7 27 16		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12407 Feldon St.	
14. FATHER'S NAME FIRST MIDDLE LAST Lillian Goodman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Cohen		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -----					
17. INFORMANT ADDRESS Joseph Sirkis; 12407 Feldon St.; Wheaton, Md.		18b. SOCIAL SECURITY NO. 214-16-3178A							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant carcinoma of breast
DUE TO, OR AS A CONSEQUENCE OF (b) breast
DUE TO, OR AS A CONSEQUENCE OF (c) breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19/82</u> to <u>5/19/82</u> , that (I) (we) last saw the deceased alive on <u>5/19/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>BARRY N. ROSENBAUM</u>		DEGREE M.D.		22c. DATE SIGNED 5/19/82		22d. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/82		23c. NAME OF CEMETERY OR CREMATORY FRIENDSHIP BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25. DATE MAY 20 1982		26. REG. BY REGISTRAR'S SIGNATURE <u>James J. Nathan</u>			
1170 Rockville Pike; Rockville, Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 1 3 4 4 0			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR			
James C Slater III				05 20 82				8:02 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 MONTHS		7 DAYS	
Male		White		12/30/81		16 MOS. YRS		16		16	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Wash., D.C.		U. S. A.				Montgomery MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hospital		N/A		N/A					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14311 Briarwood Terrace			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
James C. Slater II				Rita L. Biddle							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No		N/A		James C. Slatter II		14311 Briarwood Terr. Rckvl., Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 7589 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> (c) <u>Chromosomal abnormality</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET							
22a I certify that (I) (this hospital) attended the deceased from May 11, 1982 to May 19, 1982, that (I) (we) last saw the deceased alive on May 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
<i>Reneth N. Eisenbaum</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				5-20-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Reneth N. Eisenbaum				Childa's Bldg W. Main St							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		May 21, 1982		Gate of Heaven Cemetery		Silver Spring, Md					
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME Warner E. Pumphrey, Inc.				ADDRESS P.O. Box 7428 Sil. Spr., Md.				MAY 24 1982 Charles Jean Nathan			

BP

16

POSTED

X

1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 1 3 4 4 1									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2b. MONTH DAY YEAR				
CECILIA ELIZABETH SMITH					5 / 20 / 82				
3 SEX					4. RACE				
FEMALE					CAUCASIAN				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
JAN 22, 1901					81 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
WASH., D. C.					U.S.A.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
SILVER SPRING					HOUSEWIFE				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12b. KIND OF BUSINESS OR INDUSTRY				
HOLY CROSS HOSPITAL									
13a. STATE					13b. INSIDE CITY LIMITS?				
MARYLAND					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13c. CITY OR TOWN					13d. STREET ADDRESS				
SILVER SPRING					10124 PIERCE DRIVE				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FRANK DELTUFO					ANNIE UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO				
NO					219-54-7355				
17. INFORMANT					ADDRESS				
SON					4731 FALCON STREET				
JAMES R. SMITH					ROCKVILLE, MD. 20853				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Cryptococcal meningitis</i>									
1175 DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>Myasthenia Gravis</i>									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from APR 23, 1957, to MAY 20, 1982, that (I) (we) last saw the deceased alive on MAY 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
SERUCH KIMBLE									
9801 Georgia Ave, Silver Spring									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL 5/22/82 GATE OF HEAVEN SILVER SPRING, MONT MD.									
24. FUNERAL DIRECTOR NAME									
25a. DATE REC'D BY REGISTRAR									
25b. SIGNATURE									
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 MAY 24 1982 Francis J. Collins									

11-181-28

01

ASB 51012 11-181-28

11-181-28

11-181-28

11-181-28

11-181-28

11-181-28

11-181-28



11-181-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 4 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>John M. Smith</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5-9-82</u>		2b. HOUR <u>7:55 AM</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>9 27 1906</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Wash. D. C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County MD.</u>		
10. CITY OR TOWN OF DEATH <u>Sil. Spr.</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Legal Advisor</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>I.R.S.</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Georges</u>	13c. CITY OR TOWN <u>Takoma Pk.</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>John Smith</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ruth Chipman</u>		13e. STREET ADDRESS <u>6903 Prince George Avenue</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>577-18-7962</u>		17. INFORMANT <u>Helen G. Smith</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia + resp. insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral anoxia + degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3319</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks.</u> <u>1-2 hrs.</u> <u>years.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>extensive varicose ulcerations, probable osteomyelitis</u>					
19a. DATE OF OPERATION <u>4/6/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>tracheostomy - resp. insuff.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>debridement varicose ulcer</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>19</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>8830 Camerson St., Sil. Spr., Md.</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 31</u> , 19 <u>82</u> , to <u>May 9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stanley Kirson</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>May 9, 1982</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stanley Kirson, M. D.</u>		22e. ADDRESS <u>8830 Camerson St., Sil. Spr., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>5/11/82</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Sil. Spr., Md.</u>		25a. DATE REC'D BY REGISTRAR <u>MAY 12 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Frances San Martin</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 1 3 4 4 3

1- FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF ESTI-MATED		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF BIRTH		3. AGE (IN YEARS LAST BIRTHDAY)		4. IF UNDER 1 YR.		5. IF UNDER 24 HRS.		6. DATE PRONOUNCED DEAD	
STEVEN O. SMITH		05 25 69		12 YRS.						05 02 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hospital		student							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		PG MONT.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3938 Tynervich Ct, Bel Pre Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Lindberg Oned Smith		Wesley Henery		no		none		Wesley Smith-Mother-3938 Tynewich Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Hanging</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 10a)							
		12 P.M. 5-2-82		Found hanging from 2nd floor railing							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)		21f. LOCATION (STREET, CITY, COUNTY, STATE)							
		Inside Home		3938 TYNWICH DR. SILVERSPRING MD							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		M.D.		MEDICAL EXAMINER		DATE SIGNED					
Richard L. Whelton		Deputy				5-2-82					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
RICHARD L. WHELTON		7100 Balt Ave College Park Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)					
Burial		5/6/82		Gate of Heaven Cemetery		Silver Spring, Mont. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ALEXANDER S. POPE		2617 Pennsylvania Ave., S.E.		MAY 7 1982		Charles J. Nathan					

to be used for the purpose of

100

100

100

100

100

100

Handwritten signature

Handwritten signature

RICHARD W. WELLS

WMA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 4 4 4			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HELEN N. Smoot				2a. DATE OF DEATH MONTH DAY YEAR 05 / 01 / 82		2b. HOUR 0100	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5001 West Cedar Lane	
14. FATHER'S NAME FIRST MIDDLE LAST John G. Neubauer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha C. Ulrich		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-03-8409		17. INFORMANT ADDRESS Thomas J.J. Smoot same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4629 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Hypertensive arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes, hypothyroidism, Rheumatoid arthritis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION 4/30		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes		19c. AUTOPTICALLY EXAMINED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. INVE. LAB. FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)			
21a. INJURY OCCURRED AT WORK <input type="checkbox"/> NO <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 6320 Denhamway Blvd. Baltimore Maryland			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/30 19 82 to 5/1 19 82 , that (I/we) last saw the deceased alive on 5/1 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Robert Brischbach				DEGREE MD		22c. DATE SIGNED 5-1-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Robert Brischbach				22e. ADDRESS 6320 Denhamway Blvd. Baltimore Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 6 1982			
				25b. REGISTRAR'S SIGNATURE Frances Jan Thirion			

MEDICAL CERTIFICATION

BP

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE

100-100

0000-00

SEP 10 1900

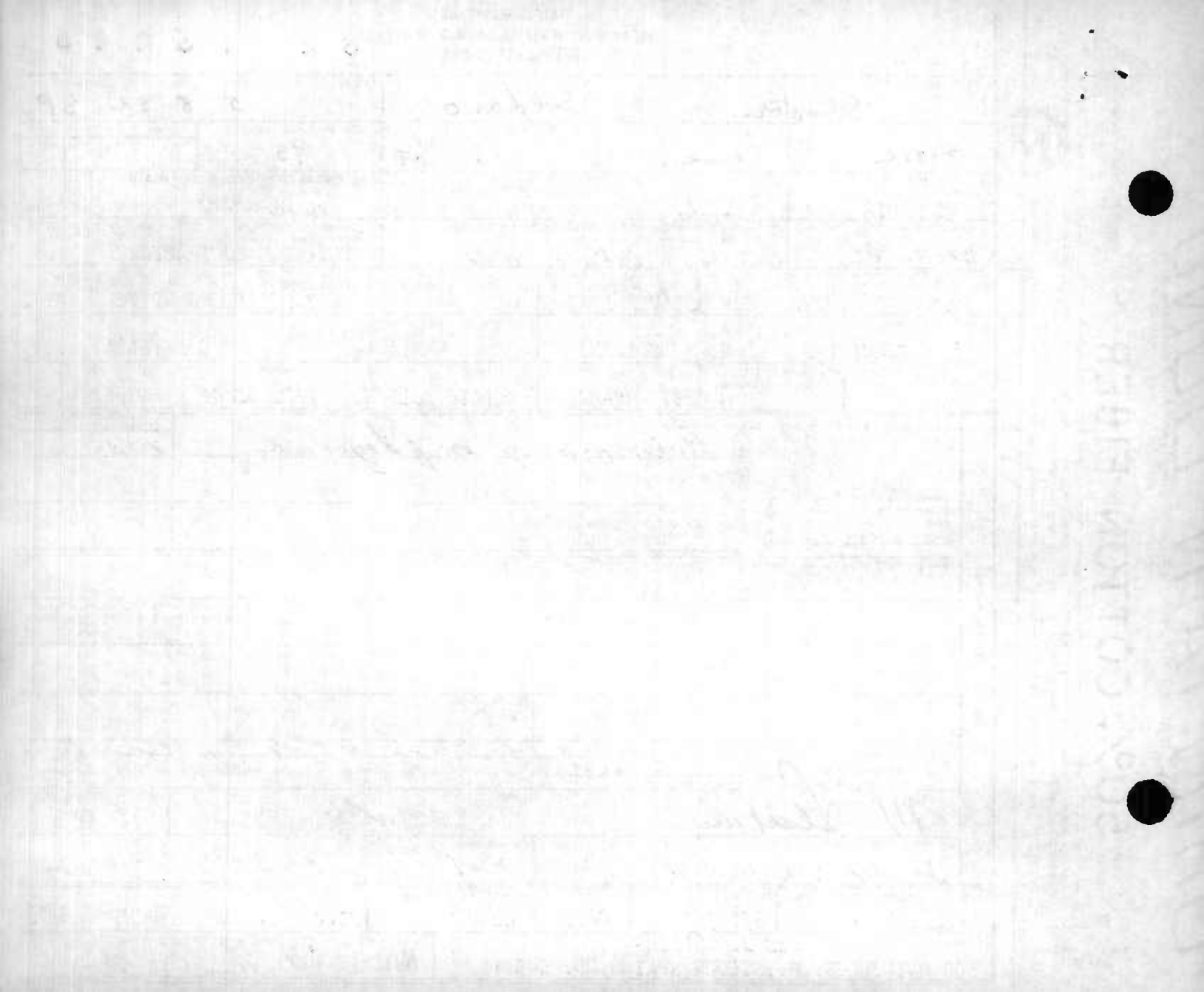
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 3 4 4 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <i>Salvatore F. Soldano</i>						2a. DATE OF DEATH		MONTH DAY YEAR HOUR <i>5 8 82 8 P.M.</i>	
3. SEX <i>male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 16 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>WHEATON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNIVERSITY NURSING HOME</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BUILDING CONTRACTOR</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MARYLAND</i>						13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS <i>413 HILLSBORO DRIVE 20902</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>STANISLAO M. SOLDANO</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARIA CANATELLA</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-42-9426</i>		17. INFORMANT ADDRESS <i>NELLIE SOLDANO SAME AS 13 WIFE</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4920</i> IMMEDIATE CAUSE (a) <i>Pulmonary emphysema.</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>13 YRS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-15-82</i> to <i>5-8-82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5-8-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. Lenkin</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5-8-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. MYRON W. LENKIN</i>						22e. ADDRESS <i>2309 Shropshire Rd Wheaton 20902</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5/11/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 13 1982</i>			
						25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 4 4 6 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) Margaret AGNES Spuhay						2a. DATE OF DEATH MONTH DAY YEAR 5 - 5 - 82		2b. HOUR 11 15 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 - XXX - 01		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. POST MASTER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.					
13a. STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1507 MILESTONE DRIVE							
14. FATHER'S NAME FIRST MIDDLE LAST REINHOLD VOEKL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA SCHACKE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 314-46-5440		17. INFORMANT DOREEN MEAD		ADDRESS SAME AS 13		DAUGHTER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Gram negative Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): old TB pleural exudates, myelofibrosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk 1 yr			
19a. DATE OF OPERATION 5/5/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 5/5/80 to 5/5 19 81 that (I/we) last saw the deceased alive on 5/5 19 81 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did/did not) view the body after death.										22c. DATE SIGNED 5/6/82			
22b. SIGNATURE Peter B. Sherer MD				DEGREE MD				22e. ADDRESS 1109 Spring St #610 Silver Spring MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD				22e. ADDRESS 1109 Spring St #610 Silver Spring MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. Martin							
26. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 4 7	
1. DECEASED NAME (TYPE OR PRINT) <i>Beatrice E. Squires</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>5/13/82</i>		2b. HOUR <i>6:05 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-31-27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>INDIANA BLIS</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		12b. BUSINESS OR INDUSTRY <i>Montgomery Schools</i>			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Warren B. Eckman</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Grace W. Zepp</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>no</i>		17. INFORMANT ADDRESS <i>Reginald K. Squires-husband-(same as decedent)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>adenocarcinoma of lung, with pleural and pericardial effusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 mo - adenocarcinoma 1 week - pericardial effusion</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>November</i> , 19 <i>81</i> , to <i>May 13</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>May 13</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Deborah Goldberg</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/14/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DEBORAH GOLDBERG</i>				22e. ADDRESS <i>1106 SPRING ST, SILVER SPRING MARYLAND</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>5-14-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, DC</i>			
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home</i>				ADDRESS <i>11800 N.H. Ave. S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 20 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 4 8

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) David R. Stevenson			2a DATE OF DEATH MONTH DAY YEAR May 12, 1982		2b HOUR 2:47pm
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR June 10, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION Metallurgical Engineer	12b KIND OF BUSINESS OR National Bureau of Standards	
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Frank M. Stevenson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Ritchie		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 278-09-1028		
17a INFORMANT Mrs. Mildred R. Stevenson, Wife			17b ADDRESS Same as item #13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myocardial infarction, Subacute, Pneumonia of lung					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:10 P.M. 19 82		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 4/10 , 19 82 to 5/12 , 19 82 , that (I) we last saw the deceased live on 5/12 , 19 82 , and that (my) our opinion death occurred on the date and hour and from the causes stated above. (If not, please state the date and hour the body was last seen.)					
22b SIGNATURE John G. Lodmell				22c DATE SIGNED 5/13/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lodmell, M.D.				22e ADDRESS 18111 Prince Philip Dr., Olney, MD.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 17, 1982		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park, Rockville, MD?	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland		25a DATE REC'D. BY REGISTRAR MAY 18 1982		25b REGISTRAR'S SIGNATURE James J. Thayer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Area 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1430, 1431, 1432, 1433, 1434, 1435, 1436, 1437, 1438, 1439, 1440, 1441, 1442, 1443, 1444, 1445, 1446, 1447, 1448, 1449, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1457, 1458, 1459, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 1470, 1471, 1472, 1473, 1474, 1475, 1476, 1477, 1478, 1479, 1480, 1481, 1482, 1483, 1484, 1485, 1486, 1487, 1488, 1489, 1490, 1491, 1492, 1493, 1494, 1495, 1496, 1497, 1498, 1499, 1500, 1501, 1502, 1503, 1504, 1505, 1506, 1507, 1508, 1509, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1517, 1518, 1519, 1520, 1521, 1522, 1523, 1524, 1525, 1526, 1527, 1528, 1529, 1530, 1531, 1532, 1533, 1534, 1535, 1536, 1537, 1538, 1539, 1540, 1541, 1542, 1543, 1544, 1545, 1546, 1547, 1548, 1549, 1550, 1551, 1552, 1553, 1554, 1555, 1556, 1557, 1558, 1559, 1560, 1561, 1562, 1563, 1564, 1565, 1566, 1567, 1568, 1569, 1570, 1571, 1572, 1573, 1574, 1575, 1576, 1577, 1578, 1579, 1580, 1581, 1582, 1583, 1584, 1585, 1586, 1587, 1588, 1589, 1590, 1591, 1592, 1593, 1594, 1595, 1596, 1597, 1598, 1599, 1600, 1601, 1602, 1603, 1604, 1605, 1606, 1607, 1608, 1609, 1610, 1611, 1612, 1613, 1614, 1615, 1616, 1617, 1618, 1619, 1620, 1621, 1622, 1623, 1624, 1625, 1626, 1627, 1628, 1629, 1630, 1631, 1632, 1633, 1634, 1635, 1636, 1637, 1638, 1639, 1640, 1641, 1642, 1643, 1644, 1645, 1646, 1647, 1648, 1649, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1659, 1660, 1661, 1662, 1663, 1664, 1665, 1666, 1667, 1668, 1669, 1670, 1671, 1672, 1673, 1674, 1675, 1676, 1677, 1678, 1679, 1680, 1681, 1682, 1683, 1684, 1685, 1686, 1687, 1688, 1689, 1690, 1691, 1692, 1693, 1694, 1695, 1696, 1697, 1698, 1699, 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1707, 1708, 1709, 1710, 1711, 1712, 1713, 1714, 1715, 1716, 1717, 1718, 1719, 1720, 1721, 1722, 1723, 1724, 1725, 1726, 1727, 1728, 1729, 1730, 1731, 1732, 1733, 1734, 1735, 1736, 1737, 1738, 1739, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1747, 1748, 1749, 1750, 1751, 1752, 1753, 1754, 1755, 1756, 1757, 1758, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1766, 1767, 1768, 1769, 1770, 1771, 1772, 1773, 1774, 1775, 1776, 1777, 1778, 1779, 1780, 1781, 1782, 1783, 1784, 1785, 1786, 1787, 1788, 1789, 1790, 1791, 1792, 1793, 1794, 1795, 1796, 1797, 1798, 1799, 1800, 1801, 1802, 1803, 1804, 1805, 1806, 1807, 1808, 1809, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822, 1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832, 1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852, 1853, 1854, 1855, 1856, 1857, 1858, 1859, 1860, 1861, 1862, 1863, 1864, 1865, 1866, 1867, 1868, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copypapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR	
X 1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		5		18 82 11 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		White		Aug. 7 1905		76 YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY	
Penn.		U.S.A.				X Montgomery MD.		Machinist		Fed. Gov.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. INSIDE CITY LIMITS?		13a. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
X Rockville		X Shady Grove Adventist Hospital		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		358 N. Summit Ave. #002		FIRST MIDDLE LAST		FIRST MIDDLE LAST	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		Harry		Jennie	
Md.		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		-		Day	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Harry		Jennie		No		578-36-1078		Margaret E. Struck		761 Vargas Ct., Gaithersburg, Md. 20878	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 melioidosis of lungs with metastasis.											
Conditions, if any, which gave rise to immediate cause (a): stopping the underlying cause last.											
(b) As above + Atrophy of brain.											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
ASHD + Atrophy of brain.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
-		-				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M.		19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 13 th 1982, to 18 th May 1982, that (I) (we) lost saw the deceased alive on 18 th May 6 PM 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Riche				MD				18 th May 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
RAMAN R. MEHRA											
22e. ADDRESS				16220 Frederick Rd., Gaithersburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		5/19/82		Lee's Crematory		Washington D.C.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Rashid Sandison 316 E. Diamond Ave. Gartner Sandison F. H. Gaithersburg, Md. 20877				MAY 20 1982				James Van Natten			

• •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

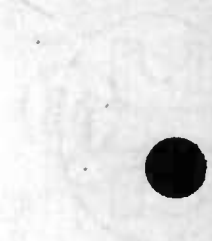
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 1 3 4 5 0				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL T. STUP					2a. DATE OF DEATH MONTH DAY YEAR May 5-7-82			2b. HOUR 9:05 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 22, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10110 Summit Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Not Available Campbell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Not Available				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-84-3614		17. INFORMANT ADDRESS Mr. John F. Terry, Son, Same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ISCHEMIC HEART DISEASE, MEGALY. DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES MELLITUS, CHRONIC ARTERIAL FIBRILLATION									
19a. DATE OF OPERATION May 7, 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Bypass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. May 7 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Heart Attack					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10110 Summit Avenue Kensington Montgomery Maryland					
22a. I certify that (I) (this hospital) attended the deceased from May 7, 1982 to May 7, 1982 , that (I) (we) last saw the deceased alive on May 7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roland Imperial MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 12 1982
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLAND IMPERIAL					22e. ADDRESS 4977 BATTERY LANE Bethesda MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Washington National			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE James J. Warren		

BP



CHICAGO, ILL. 60607
1234567890
1234567890
1234567890
1234567890

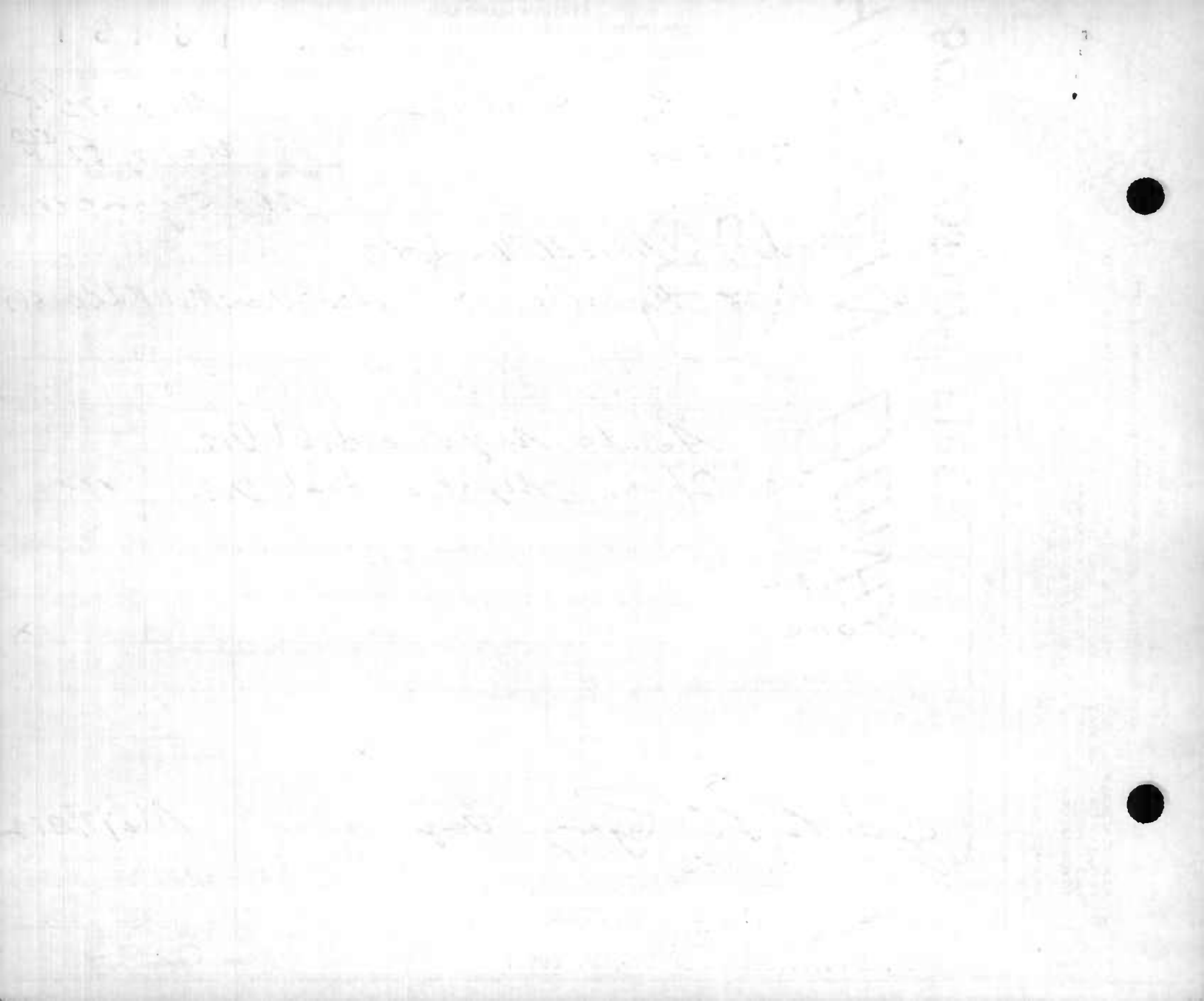
1234567890
1234567890
1234567890
1234567890

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13451	
1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <i>Virginia K Sullivan</i>										2a. DATE KNOWN OF DEATH	
4. RACE <i>W</i>										2b. HOUR <i>7:40</i>	
5. DATE OF BIRTH <i>July 5, 1922</i>										2c. DATE PRONOUNCED DEAD <i>May 2, 1982</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i>										2d. HOUR <i>5:40</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>										7b. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>	
7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Rockville</i>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12630 Viers Mill Rd Apt 619</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FOOD MANAGER</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>HAIR LANES BOWLING CENTER</i>	
13a. STATE <i>MD</i>										13b. CITY OR TOWN <i>Rockville</i>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <i>FRANK KILBY</i>										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>MAY TURNER</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>										16b. SOCIAL SECURITY NO. <i>224-22-6722</i>	
17. INFORMANT <i>DAUGHTER</i>										ADDRESS <i>59 DOW STREET ALICIA K. WOOD CHRISTIANBURG, VA 24073</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> 4291 (b) <i>Chronic Myocardial Dis.</i> (c) Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>											
19a. DATE OF OPERATION <i>None</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John S. Rogers</i> TITLE (SPECIFY) <i>M.D. Chap.</i> MEDICAL EXAMINER										DATE SIGNED <i>May 27, 1982</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i> ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>										23b. DATE <i>5/12/82</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>BURTONSVILLE UNION</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>BURTONSVILLE MONT MD.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>										25. DATE REC'D. BY REGISTRAR <i>MAY 13 1982</i> REGISTRAR'S SIGNATURE <i>James J. Nathan</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR				8 2 1 3 4 5 2					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Thomas Wesley SUNDERLAND				May 21, 1982				7:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		March 8, 1914		68 YRS.		MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Montgomery Co., MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Mt. Airy		9255 Brown Church Rd.				Clergyman			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9255 Brown Church Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
T. Stanley Sunderland				Eliza Ellen Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
No				213-03-7496		Belle W. Sunderland, Item 13			
18. CAUSE OF DEATH (Enter only one cause, including (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 19 <u>82</u> , to <u>5/21</u> , 19 <u>82</u> , that (I) <u>did</u> last saw the deceased alive on <u>5/18/82</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>James P. Kerr, M.D.</u>								May 21, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
James P. Kerr, M.D.				26618 Ridge Rd., Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		May 24, 1982		Camp Chapel		Baltimore County, Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, P.A., Damascus, Md.				MAY 24 1982		<u>James P. Kerr</u>			

... of the ...

23

2913

2

（一）

Ergonomics

1-2-1

Table 1

• 3 •

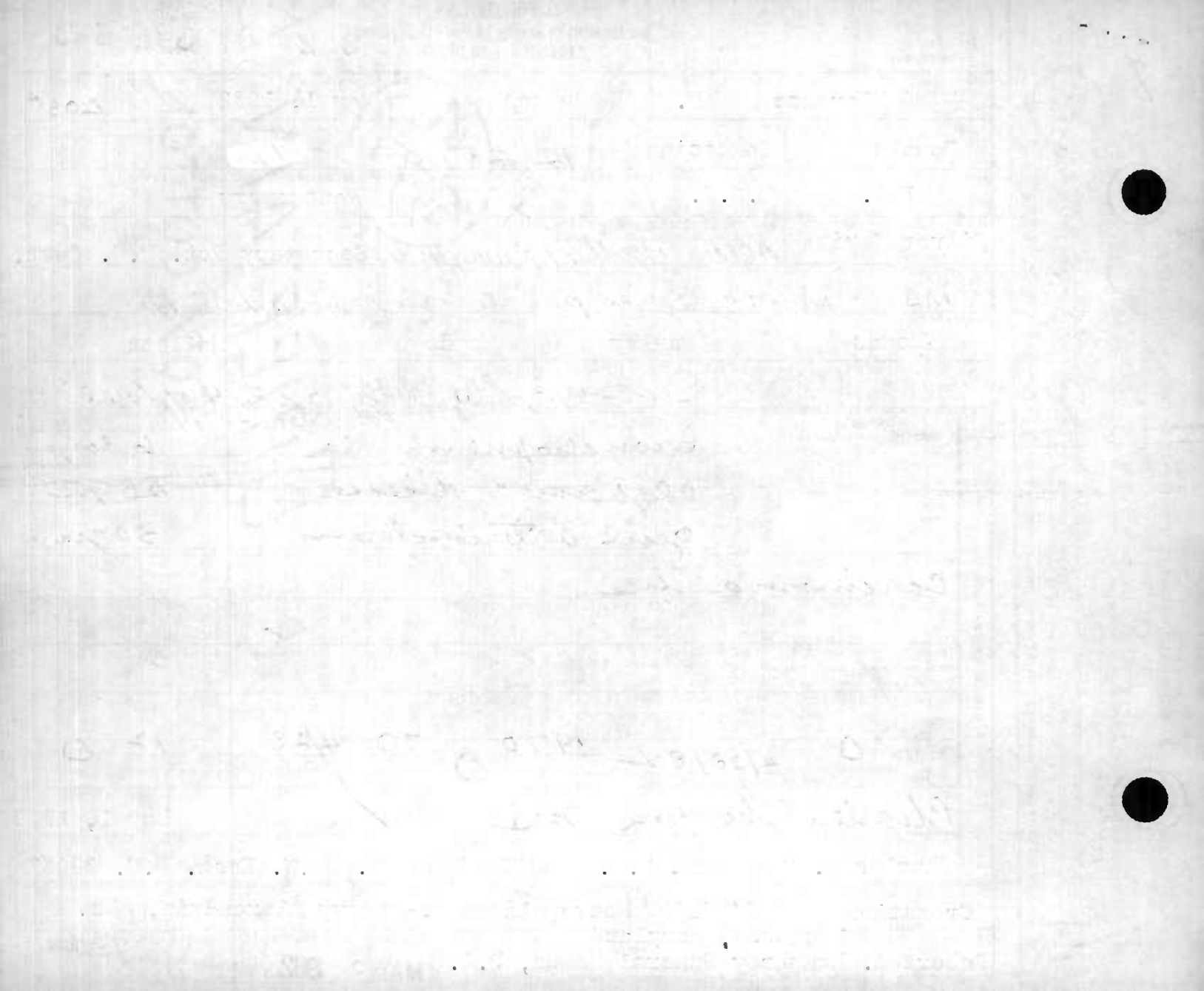
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		8 2 1 3 4 5 3 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence M. Sutton					2a. DATE OF DEATH MONTH DAY YEAR May 1, 1982			2b. HOUR 2054 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 23 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethel Woodland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary Ret.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. STATE Md.					13b. CITY OR TOWN Montg		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Manley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Mallett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 261-32-4450		17. INFORMANT ADDRESS Lily Gudy 1200 Footh of York Ft. Wash. 20744						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 3310 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alzheimer's disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gen. Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 20 yrs. 30 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma face</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1970 to 4/28 1982, that (I) (we) lost saw the deceased alive on 4/28/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles W. Thompson M.D.				22c. DATE SIGNED May 1, 1982				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Thompson, M.D.		
22e. ADDRESS 730 24th St. N.W. Wash. D.C. 20037				23a. BURIAL, CREMATION, REMOVAL CREMATION						
23b. DATE 5/2/1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION Alexandria, Va.				
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A.				25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE Frances San Antonio				

BP



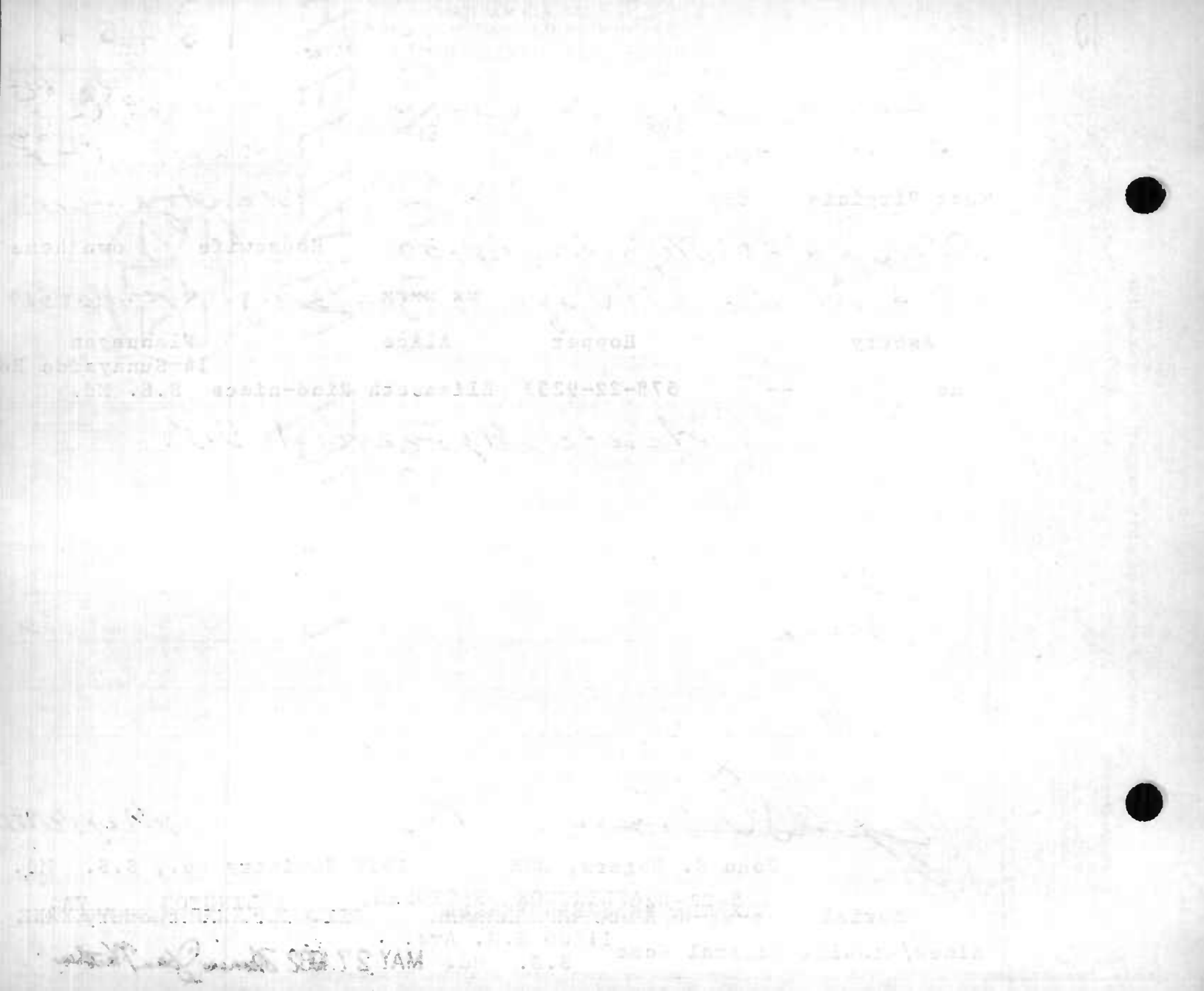
BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13454	
1. DECEASED NAME (TYPE OR PRINT) Laura Virginia Swann						2a. DATE KNOWN OF DEATH MONTH DAY YEAR May 19 1982		2b. DATE OF ESTI- MATED DEATH MONTH DAY YEAR May 19 1982		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 19 1982	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Apr 30 1896		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 86 YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR May 19 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Sil. Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 Sligo Ave Apt 309				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD				13b. CITY OR TOWN Montgomery				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 603 Sligo Ave Apt 309	
14. FATHER'S NAME FIRST MIDDLE LAST Asbury Hopper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Flannagan				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --			
16a. SOCIAL SECURITY NO. 578-22-9239				17. INFORMANT Elizabeth Rind-niece				ADDRESS 14 Sunnyside Rd S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dist DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above; held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers						TITLE (SPECIFY) DME		M.D. Dep.		DATE SIGNED May 19 1982	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME						ADDRESS 1919 Seminary Rd., S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-21-82				23c. NAME OF FUNERAL HOME OR CREMATORY Highes/Rinaldi Funeral Home			
24. FUNERAL DIRECTOR Highes/Rinaldi Funeral Home				25. DATE REC'D BY REGISTRAR May 27 1982				25b. REGISTRAR'S SIGNATURE James J. Hester			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or source.

Item 4 per phone 6/14/82 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 5 5

REG. NO.

1- FOR
STATE
REGISTRAR

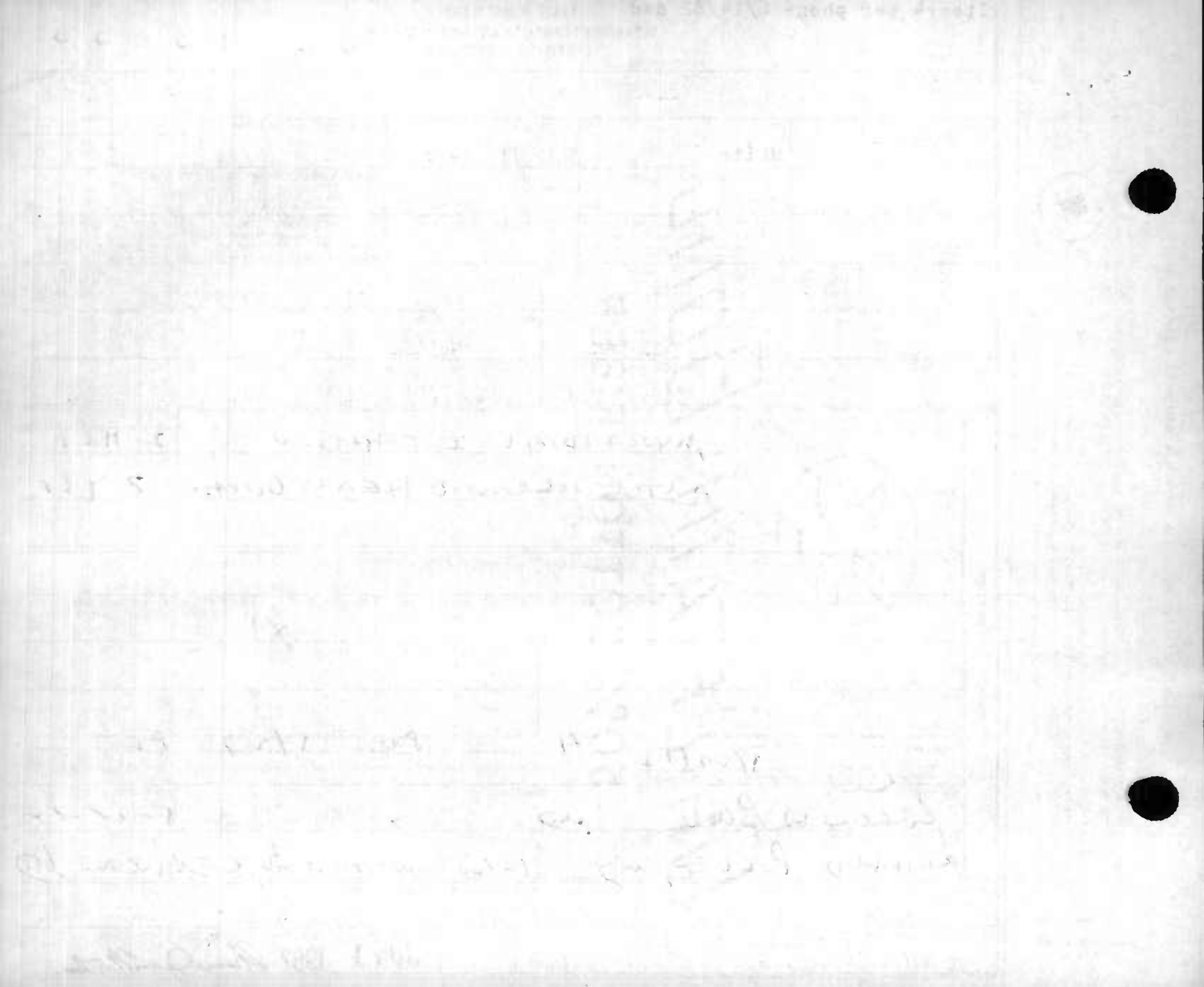
1. DECEASED NAME (TYPE OR PRINT) Marie		FIRST XX, ANN MIDDLE Talley LAST		2a. DATE OF DEATH MONTH May DAY 27 YEAR 1982		2b. HOUR 2:58P M	
3. SEX Female		4. RACE White C.		5. DATE OF BIRTH MONTH JULY DAY 18 YEAR 1939		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MED. ABSTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY UNDERSEA MED.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN KENSINGTON				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5108 FLANDERS AVENUE ASSO. 20895	
14. FATHER'S NAME FIRST FRANK MIDDLE H. LAST CURRAN				15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE DALY LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-40-7843		17. INFORMANT ADDRESS DAVID PAUL TALLEY SAME AS 13 HUSBAND			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4/100 DUE TO, OR AS A CONSEQUENCE OF (b) ARTEROSCLEROTIC HEART DISEASE 2 YRS DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 YRS	
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------------	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4 19 80 to 5/27 19 82 , that (I) (we) lost saw the deceased alive on 5/27/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard W. Pollen MD DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-28-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Pollen, MD				22e. ADDRESS 10400 Connecticut Av, Kensington MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONT STATE MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JUN 1 1982 25b. REGISTRAR'S SIGNATURE Thane Jan Heston			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted and a cause of death assigned.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

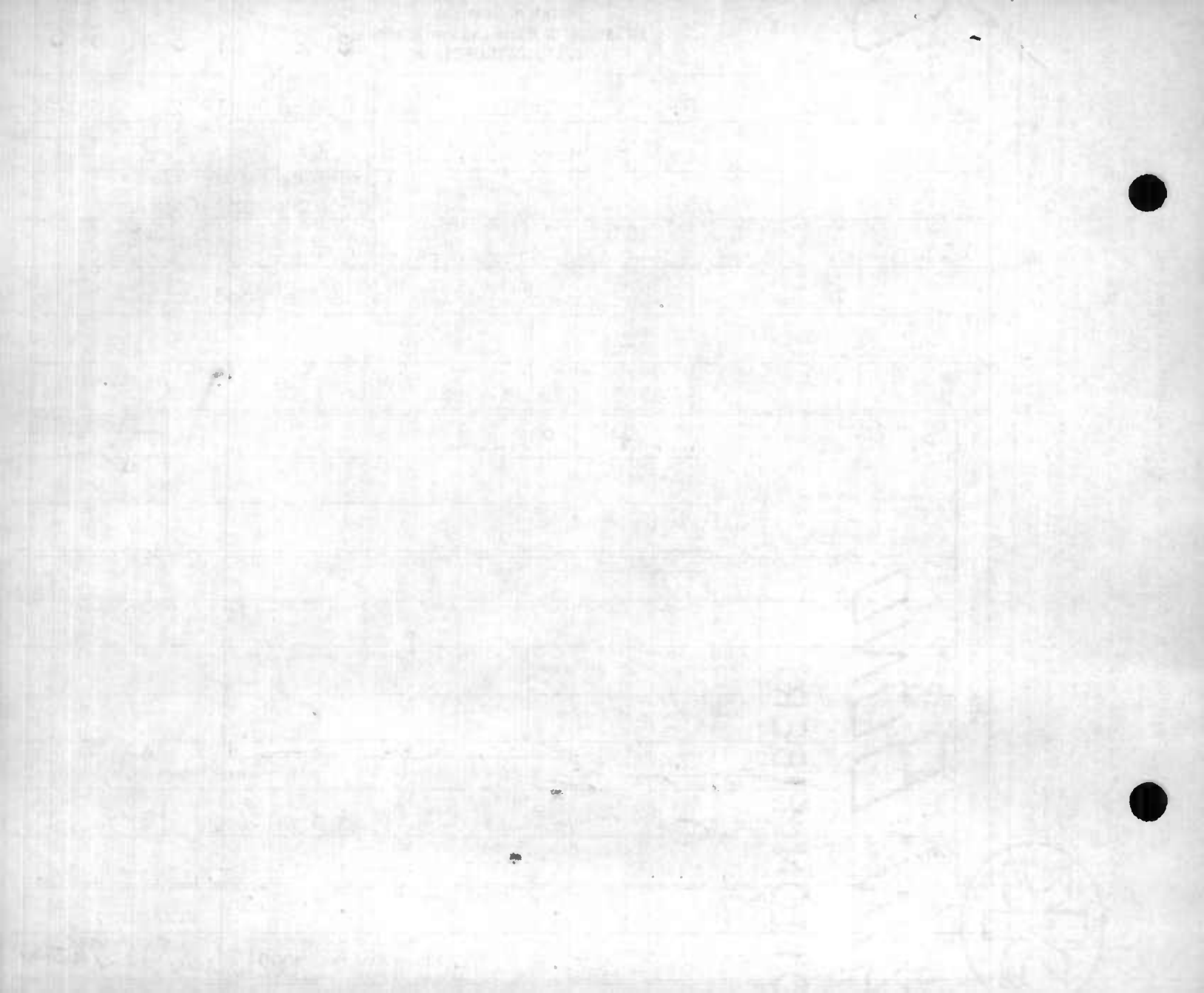
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ruth G. Tanton			2a. DATE OF DEATH MONTH DAY YEAR May 4, 1982			2b. HOUR 10:30am					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 57		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary					
13a. STATE N J		13b. COUNTY Bergen		13c. CITY OR TOWN E. Rutherford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9 Margood Court			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Both			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Emily UNK			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. 145 18 6855		
17. INFORMANT Thomas Tanton (son)			ADDRESS 605 Notley Rd. S S Md.			17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			17b. INDUSTRY Board of Education		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic Carcinoma 1552 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Apr 30, 1982 to May 4, 1982 , that (I) (we) last saw the deceased alive on May 4, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Eugene P. Flannery, M.D.						DEGREE FLANNERY			22c. DATE SIGNED 5/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Dillon, M.D.						22e. ADDRESS 18101 Prince Philip Dr., Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/6/82			23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. Cemetery			23d. LOCATION COUNTY STATE Paramus, N J		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N H Ave. S S Md.						25a. DATE REC'D. BY REGISTRAR MAY 6 1982			25b. REGISTRAR'S SIGNATURE Frances Jean Nathan		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

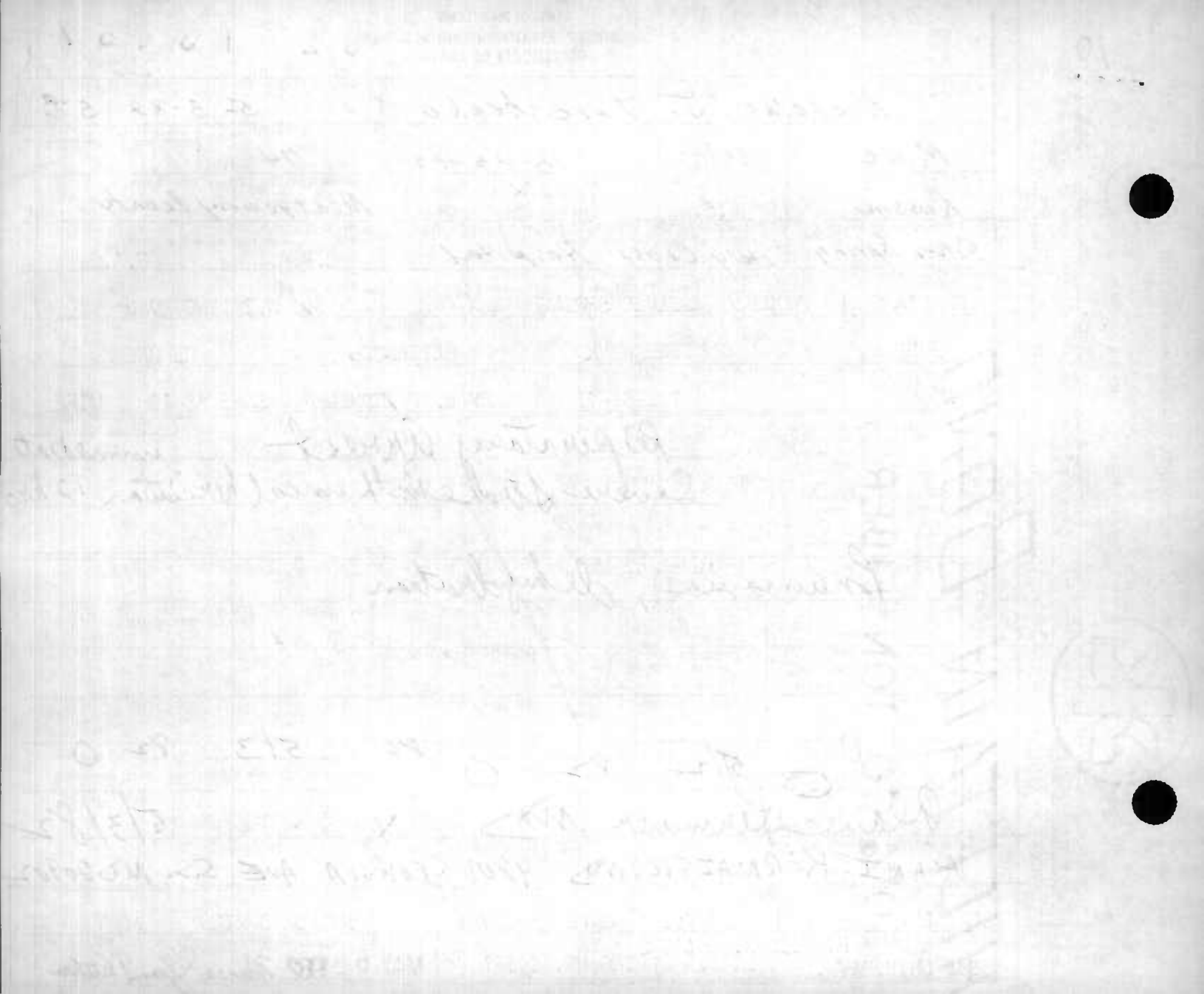
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 3 2 1 3 4 5 7							
1. DECEASED NAME (TYPE OR PRINT) <i>Nicholas J. Tereshenko</i>					2a. DATE OF DEATH		MONTH DAY YEAR <i>5-3-82</i>		2b. HOUR <i>5:45</i> AM
3 SEX <i>Male</i>	4 RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12-23-07</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>C.P.A.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>G.A.O.</i>		
13a. STATE <i>MARYLAND</i>					13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> X NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELIZABETH REMORENKO</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>182-09-9308</i>		17. INFORMANT ADDRESS <i>MARY E. TERESHENKO SAME AS 13 WIFE</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> 4360 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe stroke with uncal herniation</i> 12 hrs DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Pneumonia, dehydration</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I, this hospital) attended the deceased from <i>5/2</i> 19 <i>82</i> to <i>5/3</i> 19 <i>82</i> , that (I/we) last saw the deceased alive <i>5/2</i> 19 <i>82</i> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (live) (died) and was view (the body) after death.									
22b. SIGNATURE <i>Alan I. Kermaier, MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/3/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALAN I. KERMAIER, MD</i>		22e. ADDRESS <i>9801 GEORGIA AVE SS. MD 20902</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5/5/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>			
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		24b. ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 6 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 4 5 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACQUELINE R. THOMAS										2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-1-82 19 82 A M	
3. SEX FEMALE	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Apr. 26 1961	6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 5-1-82 11 A M		2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19801 Greenside Terrace				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY College			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19801 Greenside terrace			
14. FATHER'S NAME FIRST MIDDLE LAST John C. Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosemary Celia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 58 9094		17. INFORMANT John C. Thomas				see # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9520 IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard L. Whelton		TITLE (SPECIFY) Deputy MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON		ADDRESS 7100 Baltimore College Park									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN Silver Spring, Md.					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Homes, P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE James Van Natten					

AS 18
MAY 18

Charles George Brown

1881

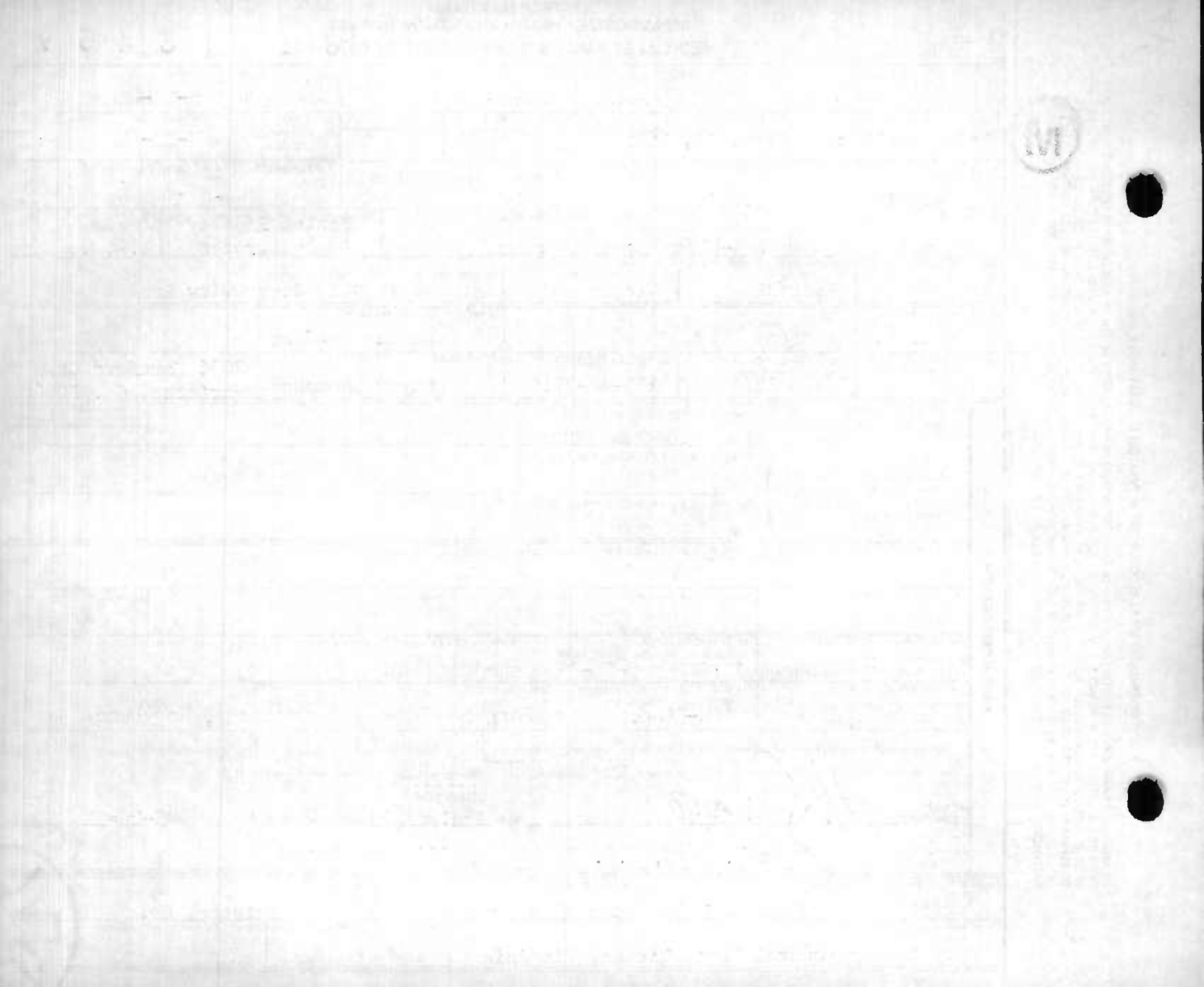
AS 18
MAY 18

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 4 5 9	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LARRY LEWIS THOMPSON						2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-28-82		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Sept. 14, 1925		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 56		7c. DATE PRONOUNCED DEAD 5-28-82		7d. HOUR 5:15 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) IBM-bldg Fernwood Roads				12a. USUAL OCCUPATION (TYPE OF WORK FOR WHICH WORKING INSTEAD) Senior Industry Administrator			12b. KIND OF BUSINESS OR INDUSTRY I.B.M., Corp	
13a. STATE Virginia						13b. CITY OR TOWN Fairfax		13c. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 9018 Streamview Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis W. Thompson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Stafford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 3/46 12/46		17. INFORMANT ADDRESS 2096 Hartford Ct. Larry Thompson, Marietta, Ga. 30060					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of abdomen</u> 9651 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00AM 5-28-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) IBM-Bldg.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Fernwood Road Bethesda, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>gunshot</u> causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>H. Guard</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-29-82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 3, 1982		23c. NAME OF CEMETERY OR CREMATORY Watermelon Creek Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Marietta, Ga.		
24. FUNERAL DIRECTOR NAME ADDRESS Money & King Funeral Home, Vienna, Virginia						25a. DATE REC'D. BY REGISTRAR JUN 7 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 6 0	
1. DECEASED NAME (TYPE OR PRINT) Ida M. Thornton						2a. DATE OF DEATH MONTH DAY YEAR May 5 - 1982		2b. HOUR 10 55 A.M.			
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) auditor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9200 Old Georgetown Road			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Kidwell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McKinney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-44-1080		17. INFORMANT ADDRESS Mr. Edward F. L. Marsh 12213 Bushey Wheaton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-21 , 19 78 , to 5-5 , 19 82 , that (I) (we) lost saw the deceased alive on 5-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold F. McCann, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-5-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN				22e. ADDRESS 3355-16th St. NW WASH D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR NAME Hysong Funeral Home, 1300 N St. N.W. Wash. D.C.				ADDRESS 1300 N St. N.W. Wash. D.C.		25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13461	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLOYD B. THRASHER										2b. DATE OF DEATH MONTH DAY YEAR 5-12-82	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 23 29		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 52 YRS.		7c. DATE PRONOUNCED DEAD 5-12-82		7d. HOUR 4:53P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County				10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove HOSpital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed tree surgeon				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland										13b. CITY OR TOWN Germantown	
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Thrasher										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther A. Mossburg	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 1947-1948 218-24-0198				17. INFORMANT ADDRESS Esther A. Thrasher same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chest injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 5:45PM 5-12-82 P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell from ladder			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) farm				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17300 Darnestown Rd. Darnestown, Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margarita A. Koroll				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-13-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial				23b. DATE 5/17/82				23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland				24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAY 19 1982			
25b. REGISTRAR'S SIGNATURE											

Washington, D.C.

Dear Mr. [Name]

Enclosed

1947-1948 118-10-1000 10-10-1000

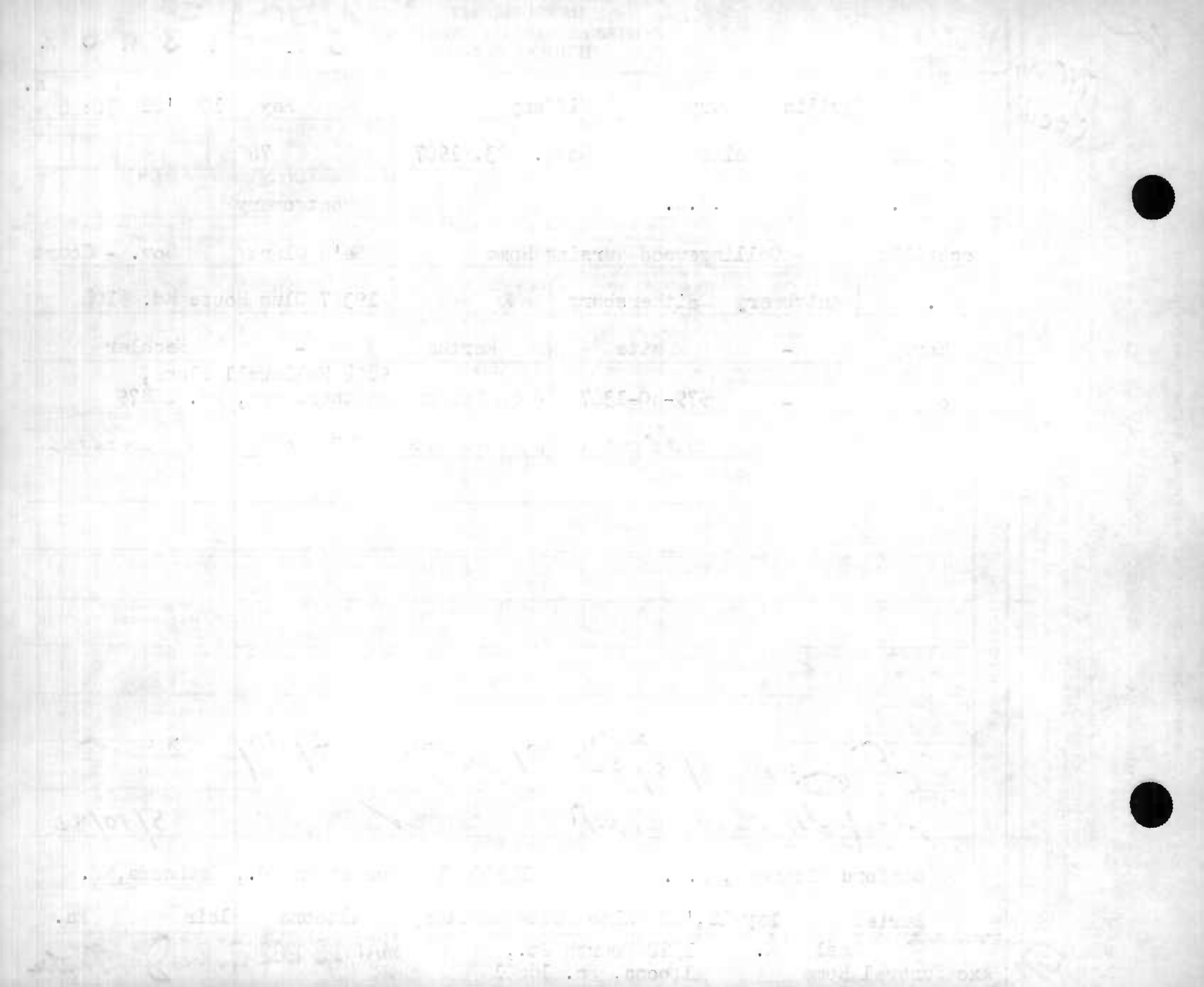
10-10-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="text-align: right;">8 2 1 3 4 6 2</div> <div style="text-align: center;">REG. NO.</div>									
<div style="display: flex; justify-content: space-between;"> <div> 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cecilia Mary Tiffany </div> <div> 2a. DATE OF DEATH MONTH DAY YEAR May 10 '82 </div> <div> 2b. HOUR a. 10:48 M </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 3 SEX Female </div> <div> 4 RACE White </div> <div> 5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1907 </div> <div> 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. </div> <div> # UNDER 1 YEAR MONTHS DAYS </div> <div> # UNDER 24 HRS HOURS MIN. </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. </div> <div> 7b. CITIZEN OF WHAT COUNTRY? U.S.A. </div> <div> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> </div> <div> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 10. CITY OR TOWN OF DEATH Rockville </div> <div> 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home </div> <div> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Re'd Clerk </div> <div> 12b. KIND OF BUSINESS OR INDUSTRY Gov. - Court </div> </div>									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <div style="display: flex; justify-content: space-between;"> <div> 13a. STATE Md. </div> <div> 13b. COUNTY Montgomery </div> <div> 13c. CITY OR TOWN Gaithersburg </div> <div> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div> <div> 13e. STREET ADDRESS 19307 Club House Rd. #104 </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 14. FATHER'S NAME FIRST MIDDLE LAST Harry - White </div> <div> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha - Kechler </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No - </div> <div> 16b. SOCIAL SECURITY NO. 579-40-1367 </div> <div> 17. INFORMANT 9804 Hallowell Place, Joan Cooper Gaithersburg, Md. 20879 </div> </div>									
18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>adeno carcinoma of pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION <div style="display: flex; justify-content: space-between;"> <div> 19a. DATE OF OPERATION </div> <div> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> <div> 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> </div> <div> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) </div> <div> 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 </div> <div> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK </div> <div> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) </div> <div> 21f. LOCATION STREET CITY OR TOWN COUNTY STATE </div> </div>									
22. I certify that (I) (this hospital) attended the deceased from <u>about 4/20/79</u> , to <u>5/10/82</u> , that (I) (we) last saw the deceased alive on <u>about 5/3/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
<div style="display: flex; justify-content: space-between;"> <div> 22b. SIGNATURE <u>Sanford N. Richmond, M.D.</u> </div> <div> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> </div> <div> 22c. DATE SIGNED <u>5/10/82</u> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sanford Richmond, M.D. </div> <div> 22e. ADDRESS 11500 Old Georgetown Rd., Bethesda, Md. </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial </div> <div> 23b. DATE May 12, '82 </div> <div> 23c. NAME OF CEMETERY OR CREMATORY Alto Reste Cemetery </div> <div> 23d. LOCATION CITY OR TOWN COUNTY STATE Altoona Blair Pa. </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> 24. FUNERAL DIRECTOR NAME Leslie E. 1520 Fourth St., Axe Funeral Home Altoona, Pa. 16601 </div> <div> 25. DATE RECEIVED BY REGISTRAR MAY 13 1982 </div> <div> 25b. REGISTRAR'S SIGNATURE <u>James San Nathan</u> </div> </div>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 3 4 6 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edmund A. Travaglini			2a. DATE OF DEATH MONTH DAY YEAR 5/10/82		2b. HOUR 12:20 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-12-15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist-Self Employed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Domenic Travaglini				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clelia DeLaurentis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Same as above Helen Travaglini (Wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC LUNG CANCER						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 yr 6 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1 , 19 80 , to 5/10 , 19 82 , that (I) met lost saw the deceased alive on 5/10 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard Cioffi		DEGREE R. CIOFFI MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 10620 Ga. Ave. S.S. Md					
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY Holy Seplucher Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Phila. Pa.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS 11800 N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Keithen	

MEDICAL CERTIFICATION

BP

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some lines being more legible than others. Faint words like "extremely", "integrated", and "notion" can be discerned in some areas.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13464

1. DECEASED NAME (TYPE OR PRINT) Helene L Trundle			2a. DATE KNOWN OF DEATH ESTIMATED May 4 1982		2b. DATE PRONOUNCED DEAD May 4 1982	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Dec 10 03 78	6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD May 4 1982
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) wardrobe clerk		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. CITY OR TOWN Prince Georges Adelphi		13c. STREET ADDRESS 1836 Metzgerott Rd	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED N. ANADAK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVIEVE (NMI) LACKIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-48-0448		17. INFORMANT ADDRESS John Thompson 9308 Alewife St Lanham MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) Yrs.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None						
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) MD Dep		DATE SIGNED May 4 1982		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7 MAY 82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		
24. FUNERAL DIRECTOR NAME Louis L. Geant		ADDRESS 9018 ANNAPOLIS RD MD 20706		25a. DATE REG'D. BY REGISTRAR MAY 10 1982		
25b. REGISTRAR'S SIGNATURE Thane		25c. REGISTRAR'S SIGNATURE PG. MD				

BP

20% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

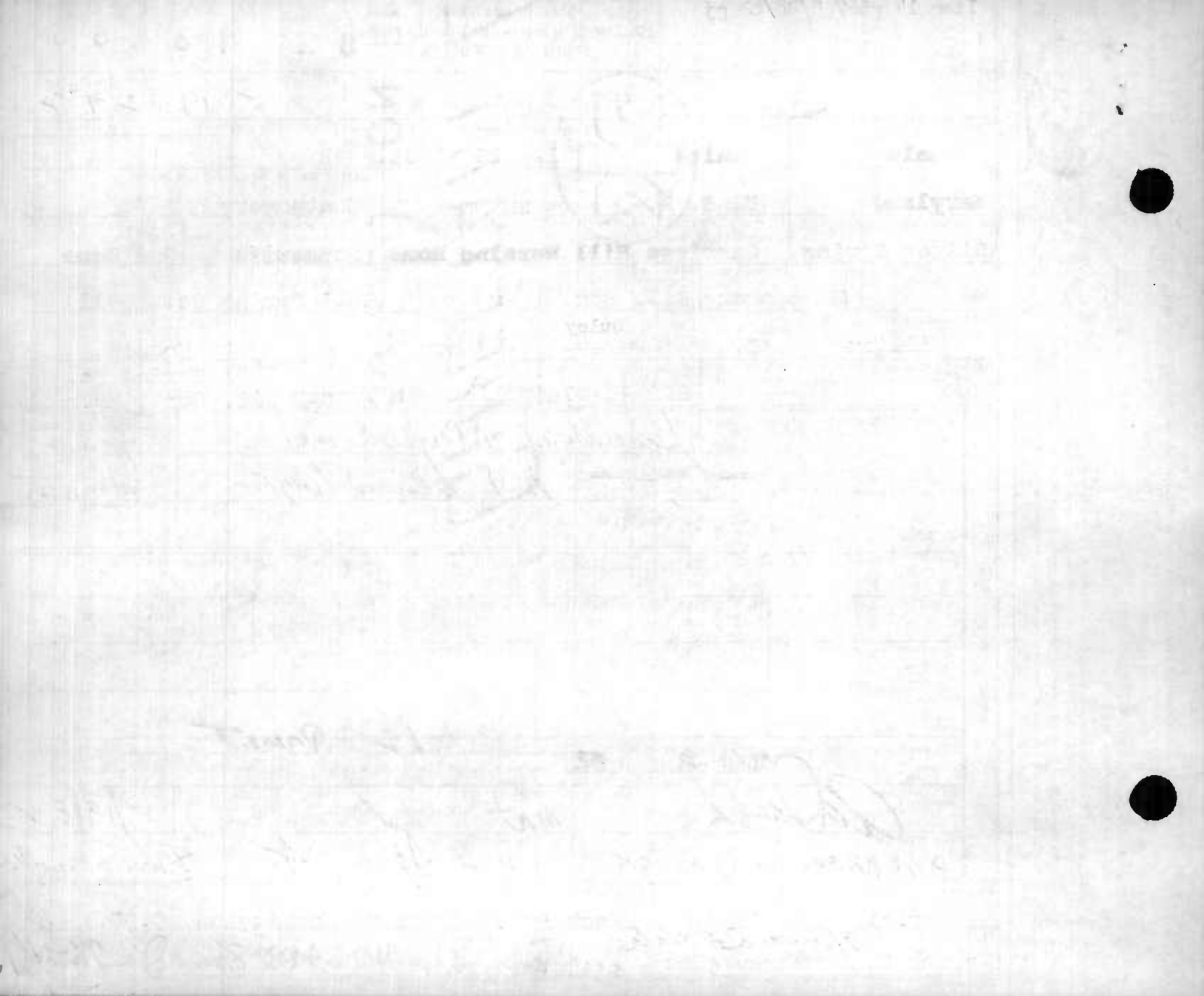
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen E. Turner					2a. DATE OF DEATH MONTH DAY YEAR 5 19 82 2b. HOUR 7:45 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1883		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1001 Spring St., #911	
14. FATHER'S NAME FIRST MIDDLE LAST William C. Duley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Mooney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No					16b. SOCIAL SECURITY NO. 216-46-0746		17. INFORMANT ADDRESS Elizabeth Turner 1001 Spring St. Sil. Spr., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) penalized arteriosclerosis 4409 DURING OR AS A CONSEQUENCE OF (b) G.I. hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 62 to Present 19 82 , that (I) (we) lost saw the deceased alive on April 29 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (with) did not view the body after death.									
22b. SIGNATURE Abraham W. Danis					22c. DATE SIGNED 5/19/82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM W. DANIS	
22e. ADDRESS 1106 Spring St. Silver Spring, Md.					22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery Washington, D. C.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.,					25a. DATE REC'D. BY REGISTRAR MAY 24 1982				
25b. REGISTRAR'S SIGNATURE Frances Jean Warthen					25c. REGISTRAR'S NAME Frances Jean Warthen				

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

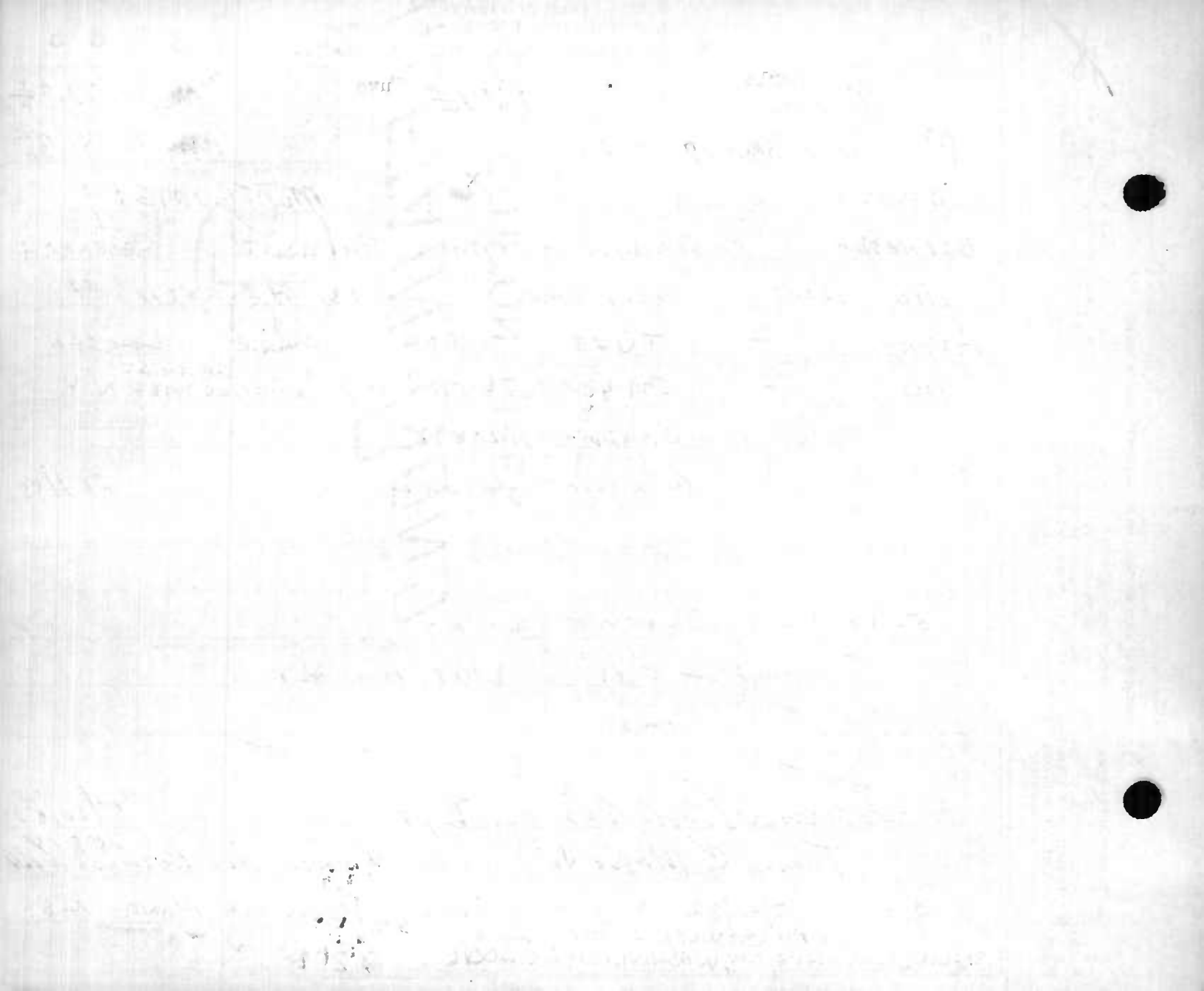
BP

DHMH-17
(VRA15 ME(5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13466

1. DECEASED NAME (TYPE OR PRINT)		FIRST Merle		MIDDLE A.		LAST TUBE		2a. DATE KNOWN OF DEATH		MONTH MAY		DAY 20		YEAR 1982		2b. HOUR 3A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		JUNE 28 1901		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		80		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY		10. CITY OR TOWN OF DEATH		BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY		RESEARCH		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		PHYSICIST	
14. FATHER'S NAME FIRST MIDDLE LAST		ATONY		TUBE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		IDA MARIE LARSEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1455 DEAN ST. SCENECTADY, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CARDIAC ARREST		DUE TO, OR AS A CONSEQUENCE OF		9554		DUE TO, OR AS A CONSEQUENCE OF		(b) GUNSHOT WOUND		DUE TO, OR AS A CONSEQUENCE OF		20 HRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		SHOT HIMSELF	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		5/20/82		20814	
EXAMINER'S NAME (TYPE OR PRINT)		FRANCIS C MAYLE JR		ADDRESS		8200 Wisconsin Ave		BETHESDA MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME		JOSEPH GAWLER'S SONS, INC.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		MAY 26 1982		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE		25f. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 6 7			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lewis R. Vasbinder						2a. DATE OF DEATH MONTH DAY YEAR 5-20-82				2b. HOUR 11:00 AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 10 31 99		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10 CITY OR TOWN OF DEATH Silver Spring Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Co. 1 minor		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11815 Salewood Rd.					
14 FATHER'S NAME FIRST MIDDLE LAST Franklin H. Vasbinder				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola King									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 178 32 2040		17 INFORMANT ADDRESS Grace Vasbinder (Wife) Same as above									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory - arrest</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD & Black Lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>none</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (a) (this hospital) attended the deceased from <u>October</u> , 19 <u>80</u> , to <u>5-20</u> , 19 <u>82</u> , that (b) (we) lost <u>saw</u> the deceased alive on <u>5-18-82</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Charles L. Franklin Jr.</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-21-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Franklin Jr.				22e. ADDRESS 1120 New Hampshire Ave S. Silver Spring Md 20904									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/25/82		23c. NAME OF CEMETERY OR CREMATORY Pringle Hill		23d. LOCATION CITY OR TOWN Croyle Township		23e. STATE Pa.					
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				25a. ADDRESS 11800 N. H. Ave S.S. Md.				25b. DATE REC'D. BY REGISTRAR MAY 27 1982		25c. REGISTRAR'S SIGNATURE <u>Charles Van Natta</u>			

BP.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of the event.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 8 2 1 3 4 6 8									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
Andres		Victory						May 31, 1982		5:00 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		7 IF UNDER 24 HRS	
Male		Caucasian		August 20, 1913		68 YRS		MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Spain		Cuba				Montgomery County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Chevy Chase Retirement Center						Shoemaker		Shoe	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4400 East-West Highway #522			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Juan Victory				Mariana Llanos							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				579-68-1995		Mrs. Blanca A. Victory same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>										2 1/2 months	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart and Vascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke (Massive)</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
<u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 19 <u>81</u> to <u>5/31</u> , 19 <u>82</u> , that (1) (we) lost saw the deceased alive on <u>5-27</u> , 19 <u>82</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
<u>Alberto Rotsztain</u>								May 31, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Alberto Rotsztain, M.D.		10401 Old Georgetown Road Bethesda, Maryland 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		June 2, 1982		Gate of Heaven Cemetery		Silver Spring, Maryland					
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				JUN 2 1982		<u>Blanca A. Victory</u>					

BP

1000 3 1000 3 1000 3 1000 3 1000 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 4 6 9 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN L. WADE				5 - 24 - 82				2 ³⁰ A M			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 11 - 21 - 04		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9 CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
12 CITY OR TOWN OF DEATH Bethesda		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Ret. & Nursing Ctr.				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mortgage Banker		15 KIND OF BUSINESS OR INDUSTRY Banking			
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda				17 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		18 STREET ADDRESS 5009 Rockmere Court					
19 FATHER'S NAME FIRST MIDDLE LAST Walker B. Lester				20 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Sherwood							
21 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				22 SOCIAL SECURITY NO. 577-22-6338		23 INFORMANT ADDRESS Peggy Slye-11701 Hitching Post Lane Rockville, Maryland					
24 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1749 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHITIS CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
25a. DATE OF OPERATION				25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
27d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27f. LOCATION STREET CITY OR TOWN COUNTY STATE					
27g. I certify that (I) (this hospital) attended the deceased from 3/22/82 to 3/24/82, that (I) (we) last saw the deceased alive on 3/24/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
27h. SIGNATURE Thos G. WARD				27i. DEGREE M.D.		27j. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27k. DATE SIGNED 5/24/82			
27l. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD				27m. ADDRESS 6116 ROBINWOOD, BETHESDA, MD 20817							
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				28b. DATE 5/27/1982		28c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		28d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
29 FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C.						29a. DATE REC'D. BY REGISTRAR MAY 27 1982		29b. REGISTRAR'S SIGNATURE Phyllis J. [Signature]			

of the

9910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 488-2783.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 7 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Luther WALDEN			2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1982		2b. HOUR 10:00AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 6, 1922		6. AGE (IN YEARS (LAST BIRTHDAY)) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE VIRGINIA	13b. COUNTY PRINCE WM.	13c. CITY OR TOWN QUANTICO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 322 3rd AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL C. WALDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE WEATHERLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1940-1966		16b. SOCIAL SECURITY NO. 266-09-2077		17. INFORMANT ADDRESS RUBY D. WALDEN 322 3rd AVE., QUANTICO, VA.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) SEPSIS SHOCK		
(c) HEMORRHAGIC SHOCK		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from MARCH 26 , 19 82 , to MAY 22 , 19 82 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on MAY 22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.			
22b. SIGNATURE Michael M. Van Ness		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 23 MAY 82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL M. VAN NESS LT MC, USNR		22e. ADDRESS NNMC, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE May 25, 1982	23c. NAME OF CEMETERY OR CREMATORY DUMFRIES CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE DUMFRIES VIRGINIA
24. FUNERAL DIRECTOR NAME Kenny Sipacab ADDRESS WOODBRIDGE, VA.		25a. DATE REC'D. BY REGISTRAR MAY 26, 1982 25b. REGISTRAR'S SIGNATURE [Signature]	
CUNNINGHAM-MOUNICASTLE			



1952-1953

1951-1952

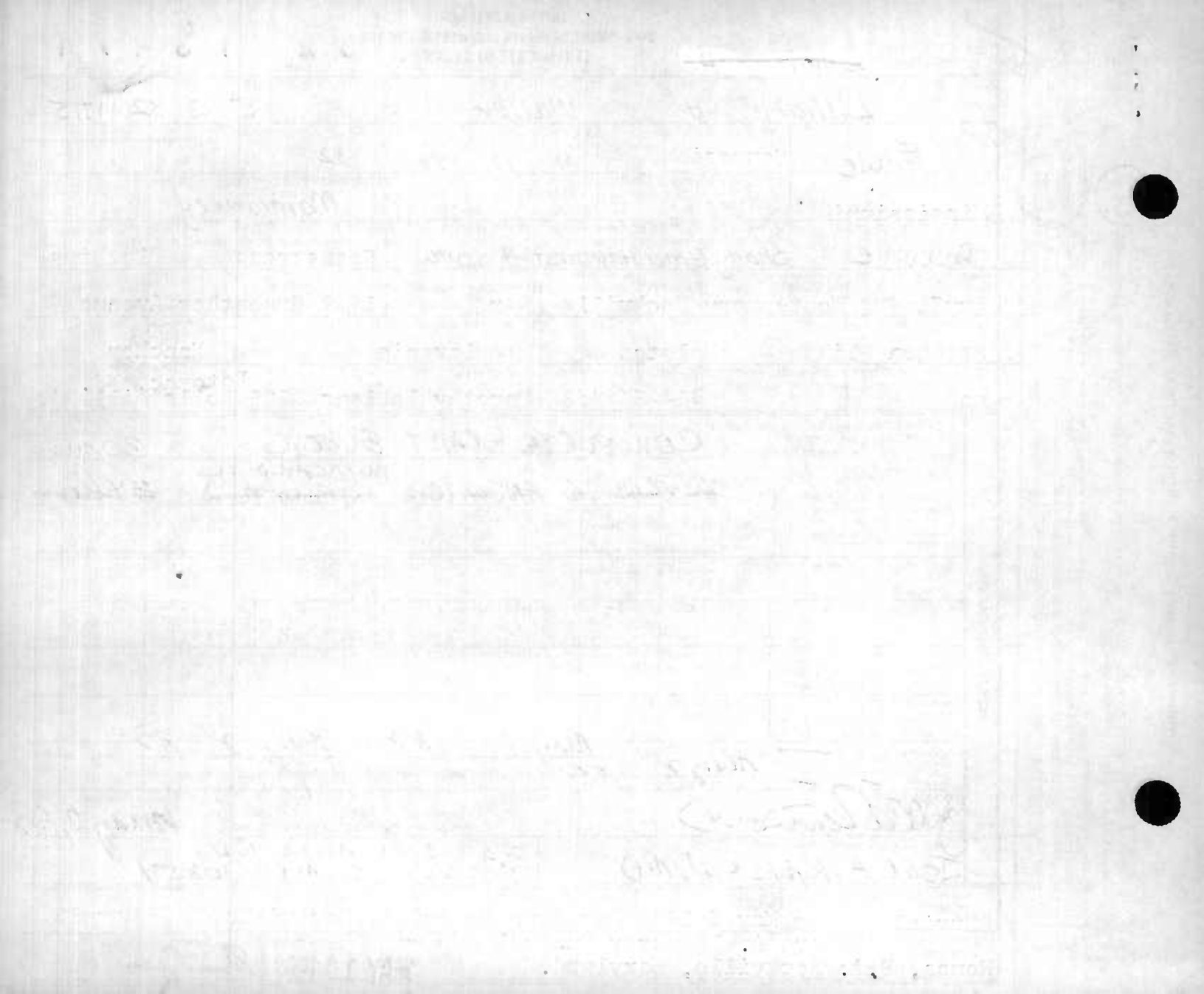
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 1 3 4 7 1			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lillian H Waller</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>5 3 82</i>		2b. HOUR <i>1715 M</i>	
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 17 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mississippi</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>				13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Stephen Olin Holston</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lavonia Fancher</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>				16b. SOCIAL SECURITY NO. <i>414 36 4685</i>		17. INFORMANT ADDRESS <i>Potomac, Md. Dorothy LeBlanc 9305 Bells Mill Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100 COMPLETE HEART BLOCK</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>EXTENSIVE ANTERIOR MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 Phases</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>May 1 19 82</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>899 VEARS MILL RD. ROCKVILLE, MD 20851</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1 19 82</i> to <i>May 2 19 82</i> , that (I) (we) last saw the deceased alive on <i>May 2 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joel A. Raitskin</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>May 2, 1982</i>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOEL A. RAISKIN, MD</i>				23b. ADDRESS <i>899 VEARS MILL RD. ROCKVILLE, MD 20851</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 5 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 10 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	



3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/8
(VRA 15, 4)

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 3 4 7 2

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel McClay Walter			2a. DATE OF DEATH MONTH DAY YEAR 5 24 82			2b. HOUR 1352M			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 05 29 09		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. CITY OR TOWN Gaithersburg		13c. STREET ADDRESS Health Care Center		
14 FATHER'S NAME FIRST MIDDLE LAST unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 267-44-6490-A		17 INFORMANT ADDRESS Mary Ellen Spicer 19536 Middletown Rd. Freeland, Md. 21053					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/20/82 19 to 5/24/82 19, that (I) (we) last saw the deceased alive on 5/20/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Henry C. Scruggs MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/24/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRUGGS MD					22e. ADDRESS 5413 Cedar La. Bethesda Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor United Meth. Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Hickory		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. ADDRESS 224 East Main Street Baltimore, Md. 21201					25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 27 1982				

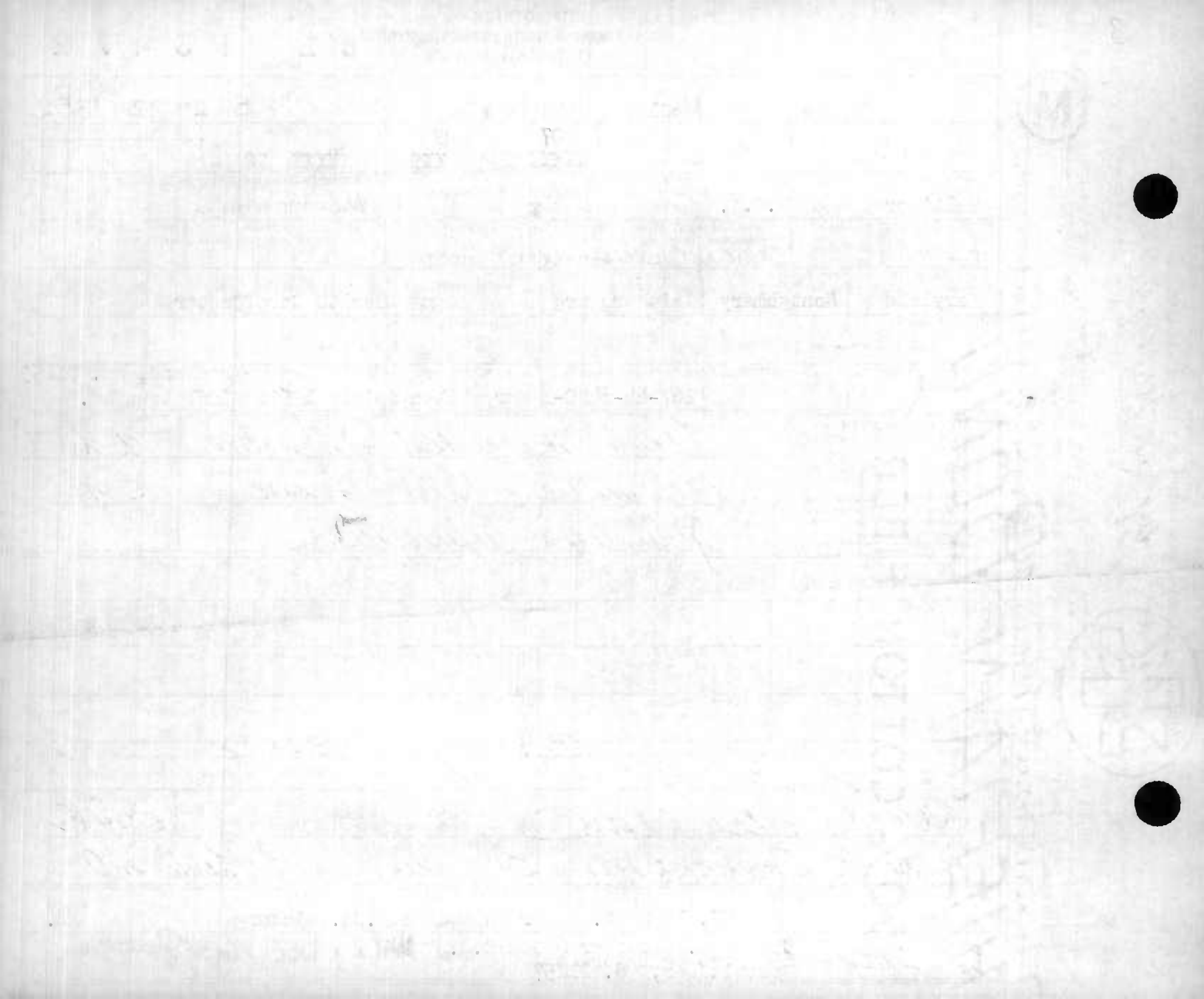
MEDICAL CERTIFICATION

Funeral Home - Thomas D. Fletcher & Son

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMMORTALITY: Item 21 is marked as "I" shows only injury or other traumatic event that the medical examiner has determined to be the cause of death.

cleared by Dr. Walter Law



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
		JEREMIAH P WARREN		MALE		CAUCASIAN		3 20 1900		82		5 25 82		12 15 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		U.S.A.				Montgomery MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring		Holy Cross Hospital		Communication Railroad											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		11617 Lockwood #103							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
unk		unk													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes		WWI		719-01-2865		Faye Warren		Birmingham Ala							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4349		Cerebral infarction				10 days									
22. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last		23. DUE TO, OR AS A CONSEQUENCE OF		24. DUE TO, OR AS A CONSEQUENCE OF		25. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		26. CHRONIC OBSTRUCTIVE LUNG DISEASE													
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED		27c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
29a. INJURY OCCURRED		29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		29c. LOCATION STREET CITY OR TOWN COUNTY STATE											
30. I certify that (a) this hospital attended the deceased from above; (b) I (we) (did) (did not) view the body after death		31. DATE OF DEATH 5/24 19 82		32. DATE OF DEATH 5/25 19 82		33. DATE OF DEATH 5/25 19 82									
34. SIGNATURE B.N. ROSENBAUM		35. DEGREE		36. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. DATE SIGNED 5/25/82									
38. PHYSICIAN'S NAME (TYPE OR PRINT)		39. ADDRESS		40. 3720 FARRAGUT AVE. KENSINGTON, MD 20845											
41. BURIAL, CREMATION, REMOVAL (SPECIFY)		42. DATE		43. NAME OF CEMETERY OR CREMATORY		44. LOCATION CITY OR TOWN COUNTY STATE									
Burial		5-27-1982		Glenwood Cemetery		Washington, N/A, D.C.									
45. FUNERAL DIRECTOR NAME ADDRESS		46. DATE REC'D. BY REGISTRAR		47. REGISTRAR'S SIGNATURE											
W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg.		MAY 28 1982		Francis J. Nathan											

●

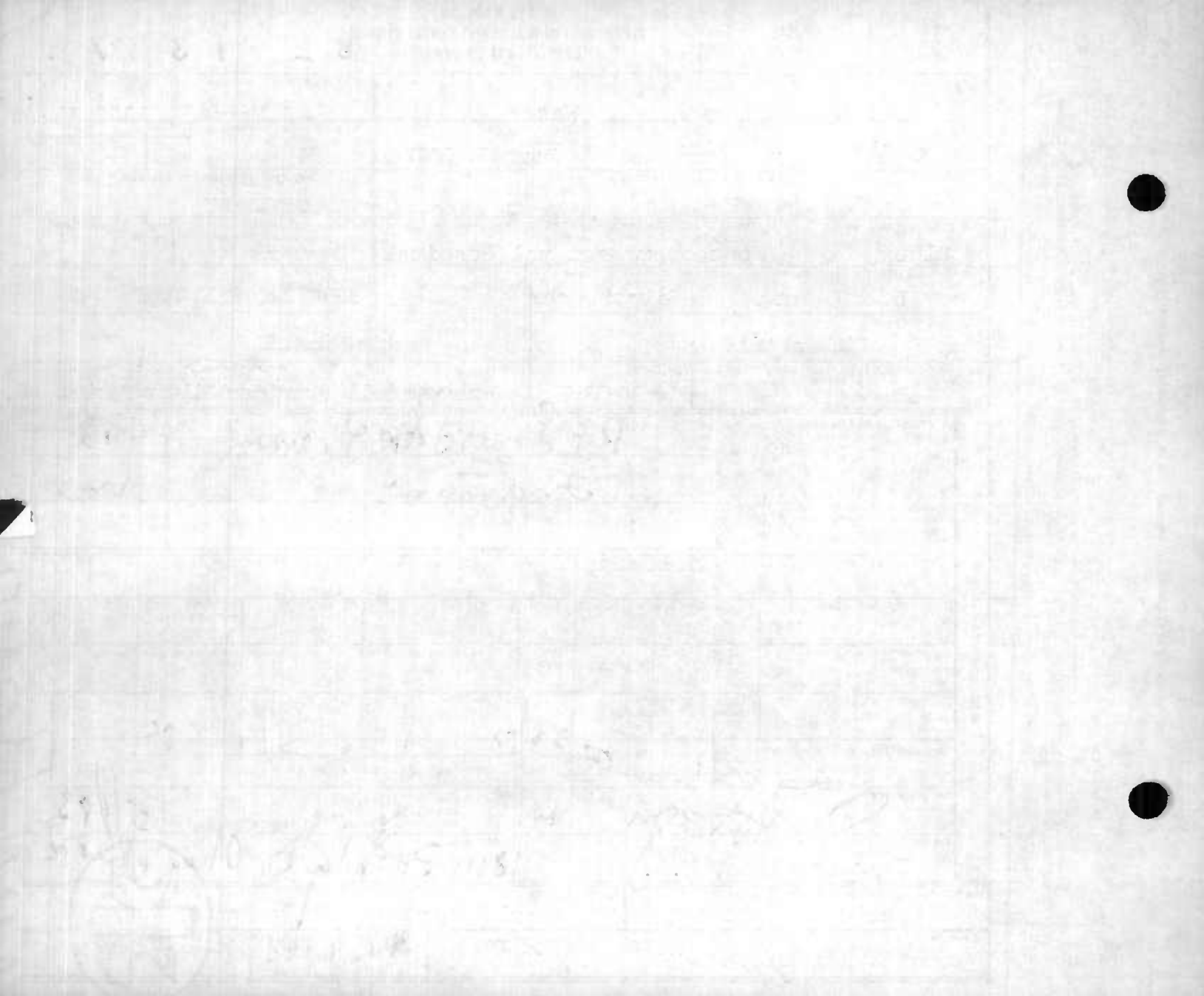
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 2 1 3 4 7 4 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Watts				2a DATE OF DEATH MONTH DAY YEAR May 1, 1982				2b HOUR A.M. 11:45	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR June 27, 1887		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7 UNDER 1 YEAR MONTHS DAYS IF OVER 1 YEAR YEARS MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery general Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.				13b COUNTY Mntg.		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Richard Hill				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Mitchell					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-30-3307		17 INFORMANT 2128 ⁵ Harlequin Terrace Jean Marshall (Daughter) Silver Spring, Md.					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT S. cerebri pneumonia</u> 2639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <u>fracture</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 m</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 m</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>5/1/82</u> to <u>5/1/82</u> , that (I) (we) lost saw the deceased alive on <u>5/1/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did not) view the body after death.									
22b SIGNATURE <u>Charles Ligon</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 5/1/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles Ligon, M.D.		22e ADDRESS 1814 P. P. Highway Dr Olney Md 20834							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-8-82		23c NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.			
24 FUNERAL DIRECTOR NAME George R. Snowden		246 N. Washington Street Rockville, Md. 20850		25a DATA REC'D. BY REGISTRAR 6/1/82		25b REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 3 4 7 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Doris Weatherall				2a. DATE OF DEATH MONTH DAY YEAR May 15 82				2b. HOUR 3 30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. STATE Tennessee		13b. COUNTY Shelby		13c. CITY OR TOWN Memphis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3558 Buxdale Street			
14. FATHER'S NAME FIRST MIDDLE LAST Sidney -- Dunaway				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian -- Curry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 412-76-7386		17. INFORMANT ADDRESS H.C. Stroupe, 8102 Whittier Blvd., Beth., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac + resp. arrest + 2° hypoxia 5150 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) 10+ yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10+ yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from home , 19 82 , to 5/15 , 19 82 , that (I) (we) last saw the deceased alive on 5/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Lewis N. Canill				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/15/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS N CANILL MD				22e. ADDRESS 5411 W. CEDAR LN, BETHESDA, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE 5/16/82		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Memphis, Tennessee			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

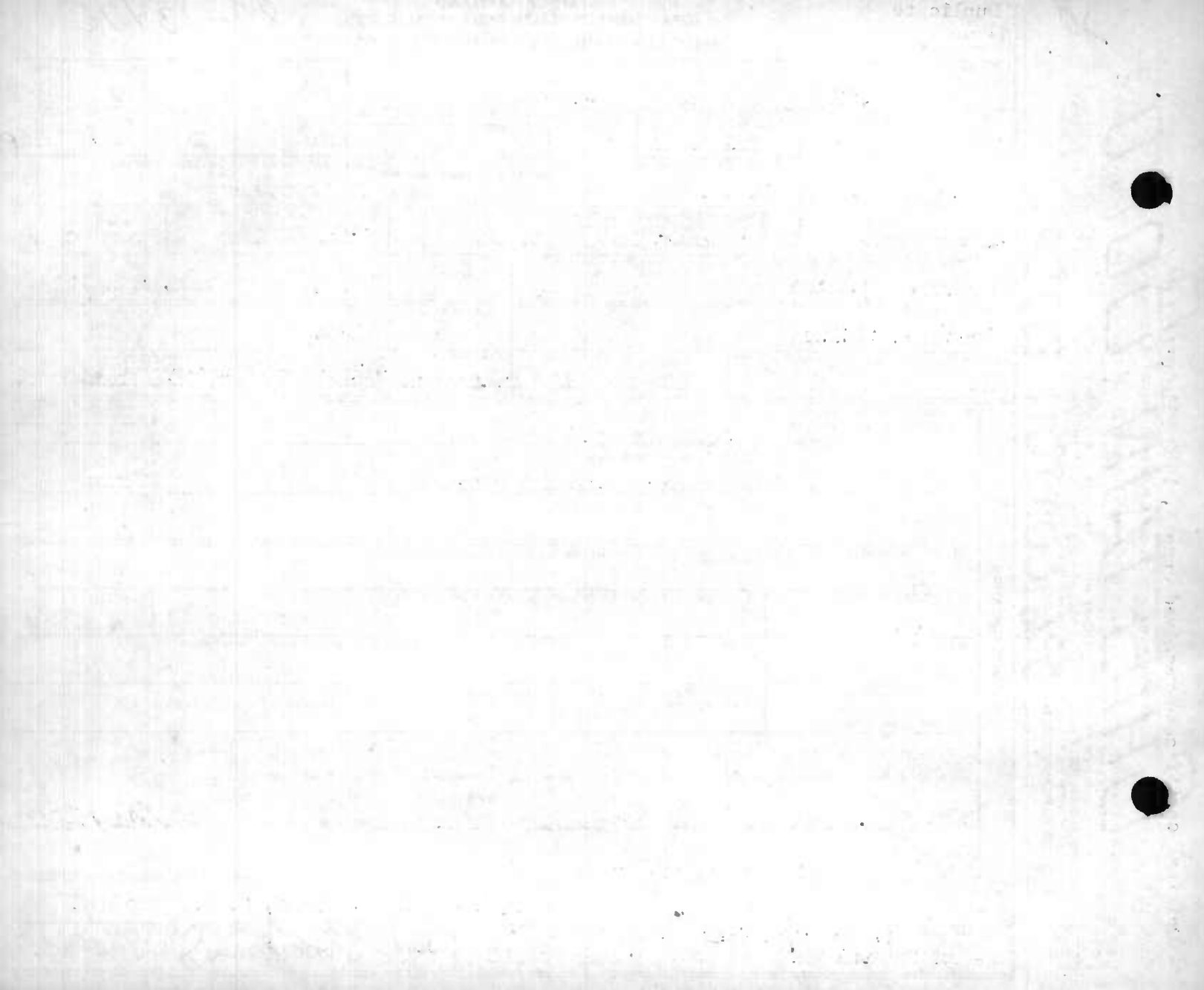
11/11/11

11/11/11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

Duplicate FOR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE				82-13476							
1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH				2b. HOUR			
Effie Mae Weaver						MAY 24, 1982				8:00A			
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Black	April 25, 22		60 YRS.						May 25, 1982		1:15A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Washington, D. C.		U.S.A.				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		2305 Greenery Lane, Apt. 202				Admin. Officer				State Dept.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2305 Greenery Lane, Apt. 202					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Senton E. Clifton		Emma M. Dulaney											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		579-22-1153		Cecelia E. Roots		Silver Spring, Md. 20910				daughter, 2209 Mark Court,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) <u>Chronic myocardial disease</u>												Years	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
TITLE (SPECIFY)													
M.D. Deputy MEDICAL EXAMINER													
DATE SIGNED May 25 1982													
EXAMINER'S NAME (TYPE OR PRINT) John L. Rogers, M. D. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		May 29 1982		Lincoln Memorial		Suitland, P. G., Maryland							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
McGuire Funeral Service, Inc., Washington, DC				JUN 3 1982		James J. Nathan							



TO HOSPITAL AND/OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 1 3 4 7 7	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
		Anne H Webb				May 1 1982		1 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
F		W		7 30 33		48 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK		U.S.A.				MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						HOUSEWIFE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		MONTGOMERY		SILVER SPRING				10200 JULEP COURT			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
WILLIAM HOAR				ADRIAN CAHILL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		422-48-2611		JAMES H. WEBB		SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Infarction											
4349											
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
4/29/82		arteriosclerosis at coronary artery									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/11 19 82 to 4/25/82 that (I) (we) last saw the deceased alive on 5/1/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body at death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Joseph F. Schanno MD						5/1/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Joseph F. Schanno		9218 Wisconsin Ave Belh. MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		5/4/82		GATE OF HEAVEN		SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME		24. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		MAY 6 1982		Francis J. Collins					

[Faint, mostly illegible handwriting at the top of the page, possibly containing a date and a name.]

[Faint handwriting in the middle section, appearing to be a list or a series of notes.]

[Faint handwriting at the bottom of the page, including what looks like a signature and a date.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VRA15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13478	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES Angus WEBBER										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 5 3 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 8 1963		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 19		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 9 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac River						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tree surgeon		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland										13b. COUNTY Montgomery	
13c. CITY OR TOWN Rockville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1021 Gilbert Road											
14. FATHER'S NAME FIRST MIDDLE LAST William H. Webber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Anne Topping						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no ---					16b. SOCIAL SECURITY NO. 215-92-3847					17. INFORMANT ADDRESS Wm. H. Webber samd as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9102 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 3:40 P.M. 5-3- 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Drowned while swimming.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Potomac River Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 5-10-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/11/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike ADDRESS Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan			

MEDICAL CERTIFICATION

1965 10

ABU

1965 10

1965 10

1965 10

1965 10

1965 10

1965 10

1965 10

1965 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 4 7 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: C. LAST: Wetzel						2a. DATE OF DEATH MONTH: May DAY: 26 YEAR: 1982		2b. HOUR 12:30P					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH: DAY: YEAR: Apr. 26, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY F. A. Adm.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D.C. 13b. COUNTY: None 13c. CITY OR TOWN: Washington						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5018 Tilden St. N.W.					
14. FATHER'S NAME FIRST: William MIDDLE: Henry LAST: Wetzel				15. MOTHER'S MAIDEN NAME FIRST: Helen MIDDLE: LAST: Clokey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS: Margaret Ann Wetzel Same as Item # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4100 DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac Spasm DUE TO, OR AS A CONSEQUENCE OF (c): Myocardial Infarction Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE PERIOD BETWEEN ONSET AND DEATH: Minutes Minutes Minutes													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: A.M. MONTH: DAY: YEAR: P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (SAY HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE:		21g. I certify that (i) (this hospital) attended the deceased from 8/26/82 to 5/26/82 and that (ii) (we) last saw the deceased alive on 5/26/82 and that (iii) (my) opinion death occurred on the date and hour and from the causes stated above. (If two physicians did not view the body after death)							
22a. SIGNATURE Thomas N. Carter M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 5/26/82					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Nelson Carter M. D.				23b. ADDRESS 5530 Wisc. Ave. Chevy Chase, Md. 20815									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/82		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.		23d. LOCATION CITY OR TOWN: Wash., D.C. COUNTY: STATE:							
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR JUN 2 1982									

MEDICAL CERTIFICATION

100-50000-5 HUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 1 3 4 8 0							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID LEE WHELCHER						2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1982		2b. HOUR 4:35PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG. 07 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY RADM/USN	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6221 MASSACHUSETTES AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST JASPER ESTEN WHELCHER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA LOUISA LONGSTREET					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1926-1960		17. INFORMANT ADDRESS MRS. MARGARET WHELCHER 6221 MASSACHUSETTES AVE. BETHESDA, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 COLON CARCINOMA, METASTATIC TO BRAIN IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 01 MAY 82 , 19 82 , to 29 MAY , 19 82 , that (we) last saw the deceased alive on 29 MAY , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.									
22b. SIGNATURE <i>Kwike for Dr. Lynch</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 29 MAY 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH M. H. LEE LT, MC, USN				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/82		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION Arlington, Va. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.				25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>			
26. FUNERAL HOME GAWLERS FUNERAL HOME WISCONSIN AVE.									

MEDICAL CERTIFICATION

0 8 0 1 1 2 0 8 0

0 2 0

0 2 0 1 1 2 0 8 0

0 2 0

0 2 0

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "COTTON" and "SUGAR" are visible.]

[Faint text at the bottom of the page, possibly a footer or additional markings.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 8 1

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Elizabeth M. Whittington</u>			2a. DATE OF DEATH MONTH <u>May</u> DAY <u>8</u> YEAR <u>1982</u>		2b. HOUR <u>8:15</u> P.M.
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH <u>9</u> DAY <u>14</u> YEAR <u>04</u>		6. AGE YEARS (LAST BIRTHDAY) <u>77</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>unknown</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>
13a. STATE <u>MD</u>		13b. COUNTY <u>Mont.</u>	13c. CITY OR TOWN <u>Kensington</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>4715 Saul Rd</u>
14. FATHER'S NAME FIRST <u>JOSEPH PATRICK</u> MIDDLE <u>CAHILL</u> LAST <u> </u>			15. MOTHER'S MAIDEN NAME FIRST <u>JANE</u> MIDDLE <u>GALVIN</u> LAST <u>XXXXXXXXXX</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>228-111-1111</u>		17. INFORMANT SON <u>MILTON A. WHITTINGTON, JR.</u> ADDRESS <u>647 RUNKLES RD. MT. AIRY, MD. 21771</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis - Shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>Perforated transverse Colon</u>	<u>24 hrs</u>
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Ovarian & Breast Carcinoma</u>	<u>2 years</u>
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u> </u>	

19a. DATE OF OPERATION <u>May 7, 1982</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Free perforation of transverse colon</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR <u> </u> A.M. <u> </u> MONTH <u> </u> DAY <u> </u> YEAR <u> </u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u> </u>	21f. LOCATION STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> 19 <u>82</u> to <u>May 8</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>May 8</u> 19 <u>82</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not divide the body after death.					
22b. SIGNATURE <u>Ronald D. Kurstin M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>5/9/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ronald D. Kurstin M.D.</u>		22e. ADDRESS <u>or Fernwood Rd Beth Md. or 1145 19th St. N.W. Wash. D.C. 20036</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>5/11/82</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (CITY OR TOWN) <u>SILVER SPRING</u> COUNTY <u>MONT</u> STATE <u>MD.</u>
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 13 1982</u>	25b. REGISTRAR'S SIGNATURE <u>Ronald D. Kurstin</u>

18. 8. 1

RECEIVED
18. 8. 1

28. 5. 1952

12

12. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

18. 8. 1

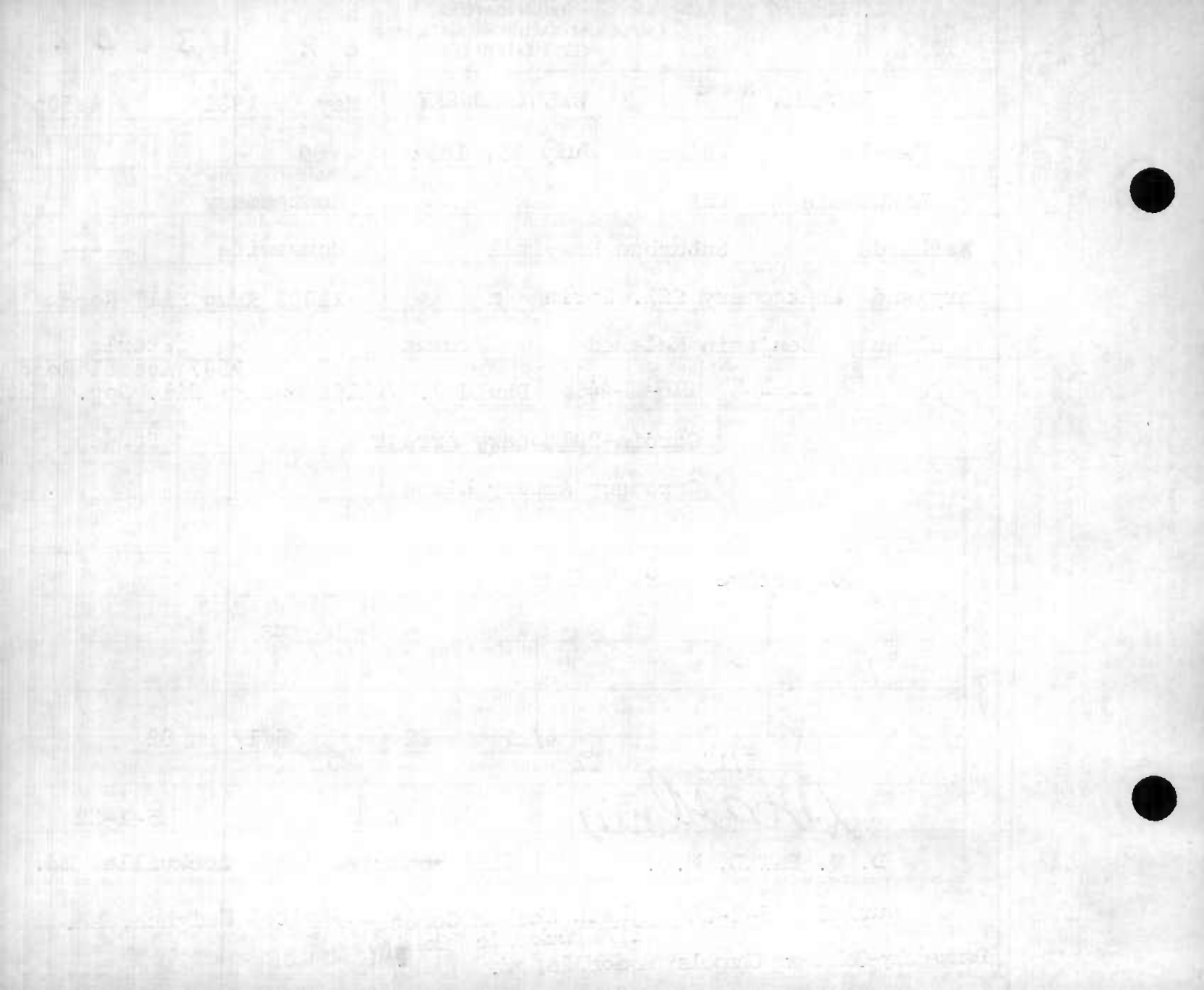
18. 8. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 1 3 4 8 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NACHAMA Naomi WILLIAMOWSKY		2a. DATE OF DEATH MONTH DAY YEAR May 1, 1982		2b. HOUR 4:50pm	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 15, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elihu Benjamin Melamed		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frumma Sterle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-88-4462		17. INFORMANT ADDRESS 9507 Avenel Road David J. Williamowsky; Sil. Spg., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Congestive Heart Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/21 , 19 82 , to 5/1/ , 19 82 , that (I) (we) lost saw the deceased alive on 5/1/ , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>D. D. Patel</i>		DEGREE		22c. DATE SIGNED 5-1-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL, M.D.		22e. ADDRESS 6121 Montrose Road; Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-2-82		23c. NAME OF CEMETERY OR CREMATORY Beth Sholom Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Capitol Heights, Md.		23e. DATE REGD. BY REGISTRAR MAY 5 1982			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; Rockville, Md.		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

item 8 #G574 12/16/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 8 3

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katie Williams		2a. DATE OF DEATH MONTH DAY YEAR 5 31 82		2b. HOUR 6 30 A M	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 5 5 89		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nsg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY MONT.	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10100 New Hamp. Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-10-0078		17. INFORMANT ADDRESS Ernest Williams 10100 New Hamp. Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 19 76, to 5-31, 19 82, that (I) (we) lost saw the deceased alive on 5-28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M Lenkin		DEGREE		22c. DATE SIGNED 5-31-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON LENKIN		22e. ADDRESS 22309 SHOREFIELD DR WHEATON 20902			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE 5/31/82	23c. NAME OF CEMETERY OR CREMATORY Wash Nat.		23d. LOCATION CITY COUNTY STATE Suitland Md.	
24. FUNERAL DIRECTOR NAME Randolph Horton		ADDRESS 600 Kennedy St. N.W. Wash.		25. REG. BY REGISTRAR JUN 10 1982	

BP

6708 BP

DHMM-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18b. Pt. 2., 19a., 19b. STATE OF MARYLAND 1. FOR STATE REGISTRAR Film#G568 6-4-82 AL DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 4 8 4 CERTIFICATE OF DEATH REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ozzie (N.M.I.) Williams						2a. DATE OF DEATH MONTH DAY YEAR May 10, 1982		2b. HOUR 7:30 A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVERSPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Electrical Co.	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23 Parkway Court Apt-B	
14. FATHER'S NAME FIRST MIDDLE LAST Sweetie Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dellie Reed					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-09-8201		17. INFORMANT Lillian E. Williams		ADDRESS Address Same as No# 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY. 4255 IMMEDIATE CAUSE (a) Chronic Ischemic Heart Failure Alcoholic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Ischemic Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1481 1481	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. ASCVD, HBP, CAD, Chronic alcoholism, Cerebrovascular Disease									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-11-82 , 19____, to 5-10-82 , 19____, that (I) (we) lost saw the deceased alive on 5-9-82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G B Petrick III MD				DEGREE MD				22c. DATE SIGNED 5-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Petrick III MD				22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.				25. DATED BY REGISTRAR 26. REGISTRAR'S SIGNATURE MAY 13 1982 Frances San Nathan					

E. Lincoln County, N.C., Fayetteville, N.C.

May 15, 1962 Ft. Lincoln Cemetery, Ironwood, E.C. Maryland

May 15, 1962
Ft. Lincoln Cemetery

May 15, 1962
Ft. Lincoln Cemetery



May 15, 1962

X

May 15, 1962

May 15, 1962

May 15, 1962

No

870-00-0001

William F. Williams

Nov 1961

Sweet

William

Belle

Nov

Mayland

P.O.

Greenbelt

X

27 Railway Court Apt-B

Mayland

U.S.A.

X

May

White

May

May

May 15, 1962

May 15, 1962

May 15, 1962

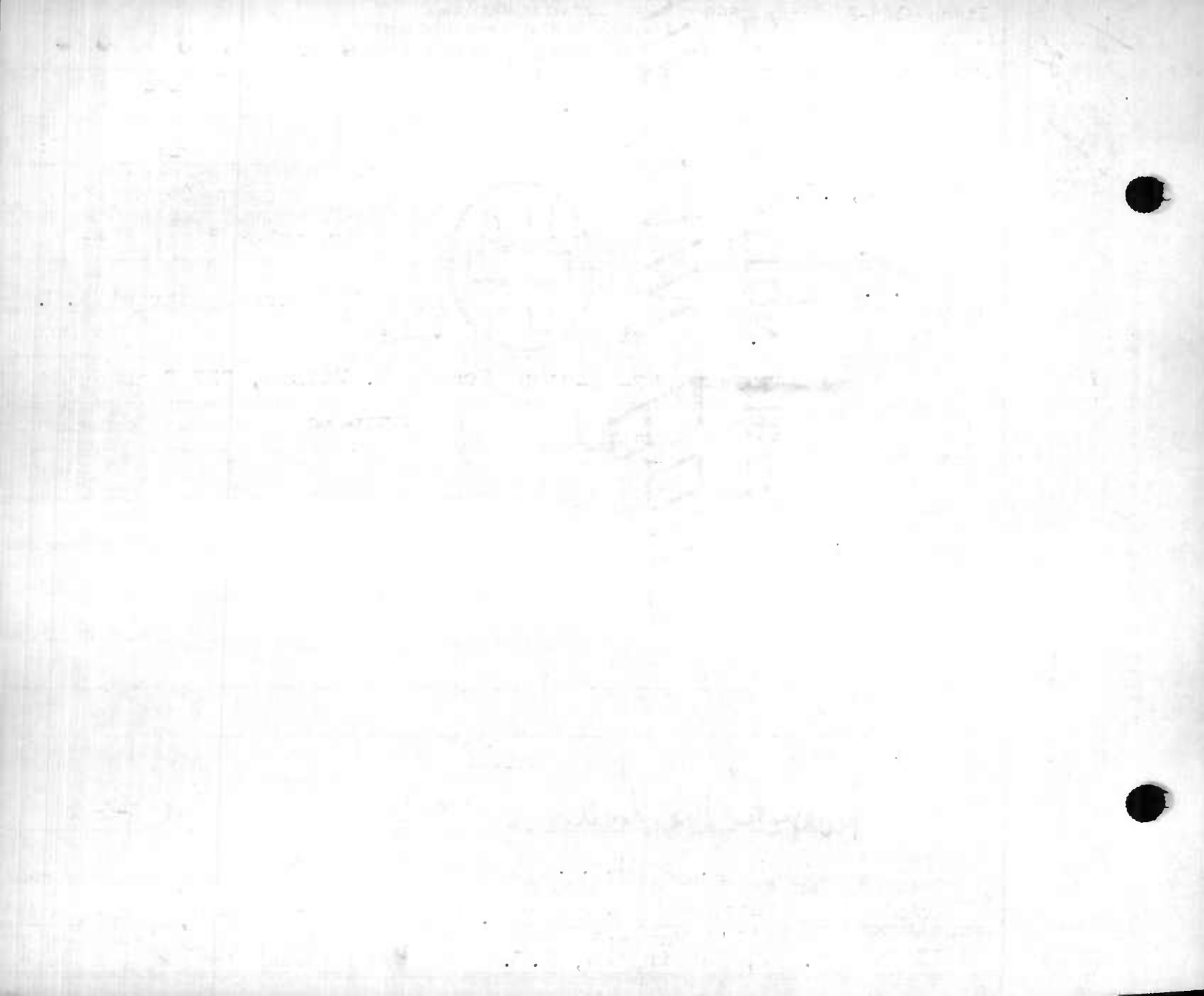


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13485	
1. DECEASED NAME (TYPE OR PRINT) REGINALD L. WILSON						2a. DATE KNOWN OF DEATH 5-6-82		2b. HOUR 19		2c. DATE OF DEATH 5-6-82	
3. SEX male		4. RACE black		5. DATE OF BIRTH Mar 19, 1950		6. AGE (IN YEARS) 32		7. IF UNDER 1 YR. MONTHS 0 DAYS 0		7. IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Takoma Pk.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington Adventist Hospital				12a. USUAL OCCUPATION unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D.C.						13b. CITY OR TOWN Washington		13c. STREET ADDRESS 337 Peabody Street N.E.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Tommie L. Wilson						15. MOTHER'S MAIDEN NAME Jessie Batson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no				16b. SOCIAL SECURITY NO. 577-68-2495				17. INFORMANT Tommie L. Wilson, 337 Peabody St N			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3049 Narcotism										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) Assistant		DATE SIGNED 5-6-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 5-11-82		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park				23d. LOCATION CITY OR TOWN Landover, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR Marshall's Funeral Home						25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE [Signature]			
ADDRESS 4217 9th St. NW, Washington, D.C.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 8 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MAY 8, 1982		2:30A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		CAUCASIAN		JAN 8, 1889		93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MINNESOTA		U.S.A.				MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WHEATON		11306 GALT AVENUE		HOUSEWIFE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		WHEATON		11306 GALT AVENUE 20902	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
JACOB		GERTRUDE		NO		N/A	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmias		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
ALLAN JAMES WITCHIE		SAME AS 13 SON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED	
		P.M. 19				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED		21h. SIGNATURE		21i. ADDRESS	
		5/10/82		Joseph M. Solinas MD		9801 GEORGIA AVENUE, SILVER SPRING, MD.	
22a. CERTIFY THAT (1) (this hospital) attended the deceased from April 22 1982, and that (2) (we) last saw the deceased alive on April 22 1982, and that in your opinion death occurred on the day and place and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. DATE REC'D. BY REGISTRAR		22c. REGISTRAR'S SIGNATURE		22d. DATE SIGNED	
		MAY 13 1982		Francis J. Collins		5/10/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		5/11/82		GATE OF HEAVEN		SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE SIGNED	
FRANCIS J. COLLINS		MAY 13 1982		Francis J. Collins		5/10/82	
2000 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

Handwritten text, possibly a signature or name, appearing in the center of the page.



12/1/72

Handwritten text, possibly a signature or name, appearing in the lower-right quadrant of the page.

BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 2 1 3 4 8 7 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MARJORIE E. WOOD					2a. DATE OF DEATH MONTH DAY YEAR HOUR 5-22-82 235p M				
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 27 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Spr.					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9124 Flower Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST William B. Hutzell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Beachley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---					16b. SOCIAL SECURITY NO. 214-36-2685		17. INFORMANT ADDRESS Richard Hutzell Ocean City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 Conditions, if any, which gave rise to immediate cause (b) CORONARY ARTERY DISEASE underlying cause last (c) MASSIVE GASTROINTESTINAL Hemorrhage									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE Pulmonary Disease, DIABETES									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 20 , 19 82 , to MAY 22 , 19 82 , that (I) (we) last saw the deceased alive on MAY 22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE BERNARD A. FITZGERALD M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard A Fitzgerald					22e. ADDRESS 217 University Blvd E, Silver Spring, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/26/82		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland		
24. FUNERAL DIRECTOR NAME Howard E. Hale					P.O. Box 7428 Warner E. Pumphrey, Inc. Sil. Spr., Md.		25a. DATE RECD. BY REGISTRAR MAY 25 1982		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

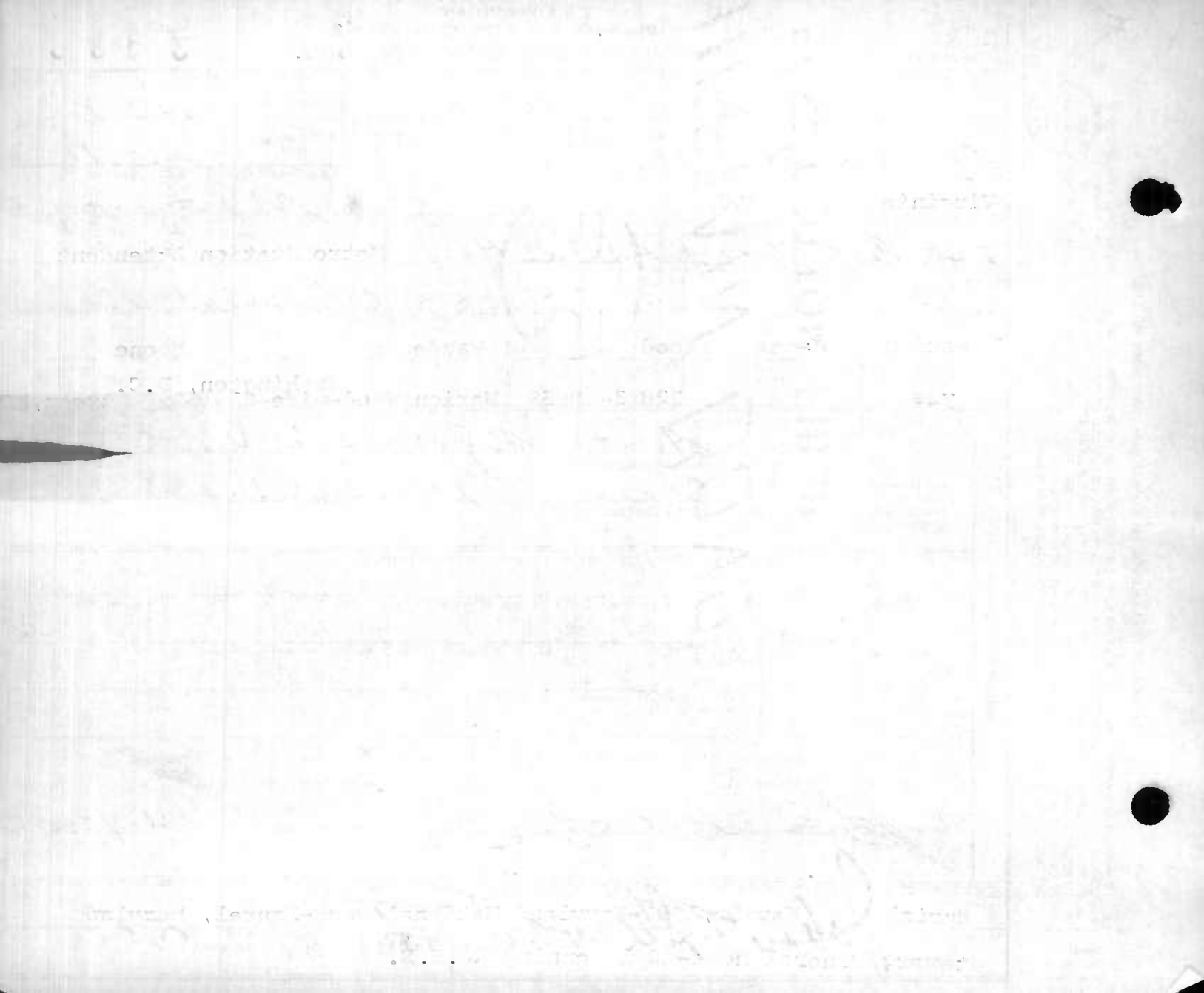
BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13488

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Wilbert Wood</i>		2a. DATE KNOWN OF DEATH ESTIMATED <i>May 23 1982</i>	2b. HOUR M
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH (MONTH DAY YEAR) <i>July 20 30</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>51</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Rock Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash Advent Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Metro Station Attendant</i>	
13a. STATE <i>DC</i>		13b. COUNTY <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Marion James Wood</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maude Boone</i>		17. INFORMANT ADDRESS <i>Washington, D.C.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>228 34 8858</i>		17. INFORMANT ADDRESS <i>Marion Wood-wife-819 52nd Street, NE</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John F. Stewart</i>		TITLE (SPECIFY) <i>Dep.</i>		DATE SIGNED <i>May 23 1982</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John F. Stewart</i>		ADDRESS		DATE SIGNED <i>May 23 1982</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 23 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland National Park-Laurel, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home</i>		ADDRESS <i>4001 Benning Rd. N.E.</i>		25. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>John F. Stewart</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 3 4 8 9 REG. NO.	
1- FOR STATE REGISTRAR					2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR		
I. DECEASED NAME (TYPE OR PRINT) Marie Wyte					May 4 1982		12:20 pm				
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7a UNDER 1 YEAR MONTHS DAYS		7b UNDER 24 HRS. HOURS MIN.	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7d CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10 CITY OR TOWN OF DEATH White Oak		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b CITY OR TOWN P.G.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 12915 Forestview Drive		
14 FATHER'S NAME FIRST MIDDLE LAST Jacob Rosnick					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rice						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a		215-48-3312		17 INFORMANT ADDRESS Eleanor Brackna See Item #13 sister					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>4-25-82</u> to <u>5-4</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4-25</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>M Snow MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 4 May 1982			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Margaret Snow MD				22e ADDRESS 9013 Flower Ave. Silver Spring, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8 May 82		23c NAME OF CEMETERY OR CREMATORY St. Nicholas		23d LOCATION CITY OR TOWN COUNTY STATE Shavertown		23e DATE REC'D. BY REGISTRAR MAY 6 1982			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi				ADDRESS 11800 N.H. Ave. Sil. Spg. Md				25e DATE REC'D. BY REGISTRAR MAY 6 1982			

Item #17 Film G567 3/20/82 re

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 3 4 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther I. Young			2a. DATE OF DEATH MONTH DAY YEAR May 9 82			2b. HOUR 7:00 p.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (IF WORK FOR 15% OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13b. STREET ADDRESS 900 Lincoln Street		13c. CITY OR TOWN Rockville					
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Cochran		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Windsor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-6786		17. INFORMANT ADDRESS Irvine R. Young, same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiorespiratory arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 hrs

4100

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) myocardial infarction

3 hrs

DUE TO, OR AS A CONSEQUENCE OF

(c) coronary heart disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-23, 1976, to 5-9, 1982, that (I) (we) last saw the deceased alive on 5-9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas G. Sinderson, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-9-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, Md. 20852					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION BEALLSVILLE, COUNTY, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Thomas G. Sinderson	

01-21-82

00759-100

Manojo, Gary

Rockville

100-100-100



100-100-100

100-100-100

100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG NO 8 2 1 3 4 9 1			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Lydia M Zetzsche						2a. DATE OF DEATH MONTH DAY YEAR May 20 1982				2b. HOUR 1:50P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 13 03		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS 78		IF UNDER 24 HRS. HOURS MIN. 1:50P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Russell Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST Herman Zetzsche		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Ruhl											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 319-34-1096		17. INFORMANT ADDRESS Michael B. Sauer, Esq.		Equitable Trust Towson, Md. Bldg.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic granulocytic leukemia 2051 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) liver failure, severe thrombocytopenia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 82 to 20 May 19 82 , that (I) (we) last saw the deceased alive on 20 May 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Donald E. Dillon		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 21 May 82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon M.D.				22e. ADDRESS 18111 Prince Philip Dr., Olney, Md. 20832									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.						25a. DATE REC'D. BY REGISTRAR MAY 28 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Nathan					

BP

1947 May 20 1947

1947

1947

1947

1947